



Substitute House Bill No. 6388

Public Act No. 13-139

AN ACT CONCERNING INTERMEDIATE CARE FACILITIES FOR INDIVIDUALS WITH INTELLECTUAL DISABILITIES.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. Subdivision (3) of section 17a-220 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2013*):

(3) "Certification" or "certified" means certification by the Department of Public Health as an intermediate care facility for [the mentally retarded] individuals with intellectual disabilities pursuant to standards set forth in the rules and regulations published in Title 42, Part 442, Subpart G of the Code of Federal Regulations;

Sec. 2. Subsections (a) to (c), inclusive, of section 17a-228 of the general statutes are repealed and the following is substituted in lieu thereof (*Effective October 1, 2013*):

(a) If a person with intellectual disability residing in a residential facility for persons with intellectual disability licensed pursuant to section 17a-227, but not certified to participate in the Title XIX Medicaid program as an intermediate care facility for [the mentally retarded] individuals with intellectual disabilities, qualifies for the program of state supplementation to the Supplemental Security

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Income Program, the Commissioner of Social Services shall pay, under such qualifying program, on behalf of such person the rate established pursuant to subsection (b) of section 17b-244 for room and board, after a reasonable deduction, as determined by the commissioner, to reflect such person's income. The Department of Developmental Services shall pay the rate established pursuant to subsection (b) of section 17b-244 for services other than room and board provided on behalf of any person whose admission to the facility has been authorized by the Department of Developmental Services.

(b) Notwithstanding the provisions of subsection (a) of this section, persons residing in residential facilities for persons with intellectual disability licensed pursuant to section 17a-227 and receiving state payment for the cost of such services on October 1, 1983, shall be deemed to have been authorized for admission by the Department of Developmental Services. In addition, any person who is admitted to a residential facility for persons with intellectual disability after October 1, 1983, and not later than December 31, 1983, which facility is licensed pursuant to said section after October 1, 1983, and who is receiving state payment for the cost of such services, shall be deemed to have been authorized for admission by the Department of Developmental Services if (1) not later than July 15, 1983, the applicant for licensure owns or has an interest in the facility or land upon which the facility shall be located, or concludes a closing transaction on any mortgage loan secured by mortgage on such facility or land, (2) such facility is licensed not later than December 31, 1983, and (3) the applicant for licensure presents evidence to the Commissioner of Developmental Services that commitments had been made by such applicant not later than July 15, 1983, for the placement of individuals in such facility.

(c) The Department of Social Services shall continue to make payments on behalf of persons residing, on or before October 1, 1983, in residential facilities licensed pursuant to section 17a-227 on or before

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October 1, 1983, but not certified as intermediate care facilities for [the mentally retarded] individuals with intellectual disabilities, and on behalf of persons authorized for admission into such facilities by the Department of Developmental Services after October 1, 1983, who are otherwise eligible for assistance under sections 17b-600 to 17b-604, inclusive. Such payment shall be on the same basis and at the same rate which is in effect on October 1, 1983, and shall continue to pay such rate until the next succeeding annual rate is determined as provided in section 17b-244 and in this section.

Sec. 3. Subsection (a) of section 17b-99a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2013*):

(a) (1) For purposes of this section, "facility" means any facility described in this subsection and for which rates are established pursuant to section 17b-340, as amended by this act.

(2) The Commissioner of Social Services shall conduct any audit of a licensed chronic and convalescent nursing home, chronic disease hospital associated with a chronic and convalescent nursing home, a rest home with nursing supervision, a licensed residential care home, as defined in section 19a-490, as amended by this act and a residential facility for [the mentally retarded] persons with intellectual disability which is licensed pursuant to section 17a-227 and certified to participate in the Title XIX Medicaid program as an intermediate care facility for [the mentally retarded] individuals with intellectual disabilities in accordance with the provisions of this section.

Sec. 4. Subsection (b) of section 17b-106 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2013*):

(b) Effective July 1, 2011, the commissioner shall provide a state

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supplement payment for recipients of Medicaid and the federal Supplemental Security Income Program who reside in long-term care facilities sufficient to increase their personal needs allowance to sixty dollars per month. Such state supplement payment shall be made to the long-term care facility to be deposited into the personal fund account of each such recipient. For the purposes of this subsection, "long-term care facility" means a licensed chronic and convalescent nursing home, a chronic disease hospital, a rest home with nursing supervision, an intermediate care facility for [the mentally retarded] individuals with intellectual disabilities or a state humane institution.

Sec. 5. Section 17b-244a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2013*):

In determining the service component of the rates to be paid by the state under sections 17b-244 and 17b-246 to private facilities and facilities operated by regional education service centers that are licensed to provide residential care pursuant to section 17a-227, but not certified to participate in the Title XIX Medicaid programs as intermediate care facilities for [persons with mental retardation] individuals with intellectual disabilities, the Commissioner of Developmental Services shall consider for each facility the actual wage and benefit costs for services and service providers, adjusted for inflation, and said commissioner shall not establish a single fixed amount for wage and benefit costs that is applicable to all such facilities.

Sec. 6. Section 17b-260d of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2013*):

The Commissioner of Social Services shall apply for a home and community-based services waiver pursuant to Section 1915(c) of the Social Security Act that will allow the commissioner to develop and implement a program for the provision of home or community-based

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services, as defined in 42 CFR 440.180, to not more than fifty persons currently receiving services under the Medicaid program who (1) have tested positive for human immunodeficiency virus or have acquired immune deficiency syndrome, and (2) would remain eligible for Medicaid if admitted to a hospital, nursing facility or intermediate care facility for [the mentally retarded] individuals with intellectual disabilities, or in the absence of the services that are requested under such waiver, would require the Medicaid covered level of care provided in such facilities.

Sec. 7. Section 17b-278 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2013*):

The Commissioner of Social Services shall amend the state's Medicaid plan to increase to thirty-six days per year the number of home leave absences allowed for a resident of an intermediate care facility for [the mentally retarded] individuals with intellectual disabilities who is receiving medical assistance.

Sec. 8. Subsection (a) of section 17b-280 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2013*):

(a) The state shall reimburse for all legend drugs provided under medical assistance programs administered by the Department of Social Services at the lower of (1) the rate established by the Centers for Medicare and Medicaid Services as the federal acquisition cost, (2) the average wholesale price minus sixteen per cent, or (3) an equivalent percentage as established under the Medicaid state plan. Notwithstanding the provisions of this section, contingent upon federal approval, on and after October 1, 2012, for independent pharmacies, the state shall reimburse for such legend drugs at the lower of (A) the rate established by the Centers for Medicare and Medicaid Services as the federal acquisition cost, (B) the average

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wholesale price minus fifteen per cent, or (C) an equivalent percentage as established under the Medicaid state plan. The state shall pay a professional fee of one dollar and seventy cents to licensed pharmacies for each prescription dispensed to a recipient of benefits under a medical assistance program administered by the Department of Social Services in accordance with federal regulations. On and after September 4, 1991, payment for legend and nonlegend drugs provided to Medicaid recipients shall be based upon the actual package size dispensed. Effective October 1, 1991, reimbursement for over-the-counter drugs for such recipients shall be limited to those over-the-counter drugs and products published in the Connecticut Formulary, or the cross reference list, issued by the commissioner. The cost of all over-the-counter drugs and products provided to residents of nursing facilities, chronic disease hospitals, and intermediate care facilities for [the mentally retarded] individuals with intellectual disabilities shall be included in the facilities' per diem rate. Notwithstanding the provisions of this subsection, no dispensing fee shall be issued for a prescription drug dispensed to a ConnPACE or Medicaid recipient who is a Medicare Part D beneficiary when the prescription drug is a Medicare Part D drug, as defined in Public Law 108-173, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.

Sec. 9. Section 17b-340 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2013*):

(a) The rates to be paid by or for persons aided or cared for by the state or any town in this state to licensed chronic and convalescent nursing homes, to chronic disease hospitals associated with chronic and convalescent nursing homes, to rest homes with nursing supervision, to licensed residential care homes, as defined by section 19a-490, as amended by this act, and to residential facilities for [the mentally retarded] persons with intellectual disability which are licensed pursuant to section 17a-227 and certified to participate in the

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Title XIX Medicaid program as intermediate care facilities for [the mentally retarded] individuals with intellectual disabilities, for room, board and services specified in licensing regulations issued by the licensing agency shall be determined annually, except as otherwise provided in this subsection, after a public hearing, by the Commissioner of Social Services, to be effective July first of each year except as otherwise provided in this subsection. Such rates shall be determined on a basis of a reasonable payment for such necessary services, which basis shall take into account as a factor the costs of such services. Cost of such services shall include reasonable costs mandated by collective bargaining agreements with certified collective bargaining agents or other agreements between the employer and employees, provided "employees" shall not include persons employed as managers or chief administrators or required to be licensed as nursing home administrators, and compensation for services rendered by proprietors at prevailing wage rates, as determined by application of principles of accounting as prescribed by said commissioner. Cost of such services shall not include amounts paid by the facilities to employees as salary, or to attorneys or consultants as fees, where the responsibility of the employees, attorneys, or consultants is to persuade or seek to persuade the other employees of the facility to support or oppose unionization. Nothing in this subsection shall prohibit inclusion of amounts paid for legal counsel related to the negotiation of collective bargaining agreements, the settlement of grievances or normal administration of labor relations. The commissioner may, in his discretion, allow the inclusion of extraordinary and unanticipated costs of providing services which were incurred to avoid an immediate negative impact on the health and safety of patients. The commissioner may, in his discretion, based upon review of a facility's costs, direct care staff to patient ratio and any other related information, revise a facility's rate for any increases or decreases to total licensed capacity of more than ten beds or changes to its number of licensed rest home with nursing supervision beds and

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chronic and convalescent nursing home beds. The commissioner may so revise a facility's rate established for the fiscal year ending June 30, 1993, and thereafter for any bed increases, decreases or changes in licensure effective after October 1, 1989. Effective July 1, 1991, in facilities which have both a chronic and convalescent nursing home and a rest home with nursing supervision, the rate for the rest home with nursing supervision shall not exceed such facility's rate for its chronic and convalescent nursing home. All such facilities for which rates are determined under this subsection shall report on a fiscal year basis ending on the thirtieth day of September. Such report shall be submitted to the commissioner by the thirty-first day of December. The commissioner may reduce the rate in effect for a facility which fails to report on or before such date by an amount not to exceed ten per cent of such rate. The commissioner shall annually, on or before the fifteenth day of February, report the data contained in the reports of such facilities to the joint standing committee of the General Assembly having cognizance of matters relating to appropriations. For the cost reporting year commencing October 1, 1985, and for subsequent cost reporting years, facilities shall report the cost of using the services of any nursing pool employee by separating said cost into two categories, the portion of the cost equal to the salary of the employee for whom the nursing pool employee is substituting shall be considered a nursing cost and any cost in excess of such salary shall be further divided so that seventy-five per cent of the excess cost shall be considered an administrative or general cost and twenty-five per cent of the excess cost shall be considered a nursing cost, provided if the total nursing pool costs of a facility for any cost year are equal to or exceed fifteen per cent of the total nursing expenditures of the facility for such cost year, no portion of nursing pool costs in excess of fifteen per cent shall be classified as administrative or general costs. The commissioner, in determining such rates, shall also take into account the classification of patients or boarders according to special care requirements or classification of the facility according to such factors

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as facilities and services and such other factors as he deems reasonable, including anticipated fluctuations in the cost of providing such services. The commissioner may establish a separate rate for a facility or a portion of a facility for traumatic brain injury patients who require extensive care but not acute general hospital care. Such separate rate shall reflect the special care requirements of such patients. If changes in federal or state laws, regulations or standards adopted subsequent to June 30, 1985, result in increased costs or expenditures in an amount exceeding one-half of one per cent of allowable costs for the most recent cost reporting year, the commissioner shall adjust rates and provide payment for any such increased reasonable costs or expenditures within a reasonable period of time retroactive to the date of enforcement. Nothing in this section shall be construed to require the Department of Social Services to adjust rates and provide payment for any increases in costs resulting from an inspection of a facility by the Department of Public Health. Such assistance as the commissioner requires from other state agencies or departments in determining rates shall be made available to him at his request. Payment of the rates established hereunder shall be conditioned on the establishment by such facilities of admissions procedures which conform with this section, section 19a-533 and all other applicable provisions of the law and the provision of equality of treatment to all persons in such facilities. The established rates shall be the maximum amount chargeable by such facilities for care of such beneficiaries, and the acceptance by or on behalf of any such facility of any additional compensation for care of any such beneficiary from any other person or source shall constitute the offense of aiding a beneficiary to obtain aid to which he is not entitled and shall be punishable in the same manner as is provided in subsection (b) of section 17b-97. For the fiscal year ending June 30, 1992, rates for licensed residential care homes and intermediate care facilities for [the mentally retarded] individuals with intellectual disabilities may receive an increase not to exceed the most recent annual increase in the Regional Data Resources Incorporated

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McGraw-Hill Health Care Costs: Consumer Price Index (all urban)-All Items. Rates for newly certified intermediate care facilities for [the mentally retarded] individuals with intellectual disabilities shall not exceed one hundred fifty per cent of the median rate of rates in effect on January 31, 1991, for intermediate care facilities for [the mentally retarded] individuals with intellectual disabilities certified prior to February 1, 1991. Notwithstanding any provision of this section, the Commissioner of Social Services may, within available appropriations, provide an interim rate increase for a licensed chronic and convalescent nursing home or a rest home with nursing supervision for rate periods no earlier than April 1, 2004, only if the commissioner determines that the increase is necessary to avoid the filing of a petition for relief under Title 11 of the United States Code; imposition of receivership pursuant to sections 19a-541 to 19a-549, inclusive; or substantial deterioration of the facility's financial condition that may be expected to adversely affect resident care and the continued operation of the facility, and the commissioner determines that the continued operation of the facility is in the best interest of the state. The commissioner shall consider any requests for interim rate increases on file with the department from March 30, 2004, and those submitted subsequently for rate periods no earlier than April 1, 2004. When reviewing a rate increase request the commissioner shall, at a minimum, consider: (1) Existing chronic and convalescent nursing home or rest home with nursing supervision utilization in the area and projected bed need; (2) physical plant long-term viability and the ability of the owner or purchaser to implement any necessary property improvements; (3) licensure and certification compliance history; (4) reasonableness of actual and projected expenses; and (5) the ability of the facility to meet wage and benefit costs. No rate shall be increased pursuant to this subsection in excess of one hundred fifteen per cent of the median rate for the facility's peer grouping, established pursuant to subdivision (2) of subsection (f) of this section, unless recommended by the commissioner and approved by the Secretary of the Office of

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Policy and Management after consultation with the commissioner. Such median rates shall be published by the Department of Social Services not later than April first of each year. In the event that a facility granted an interim rate increase pursuant to this section is sold or otherwise conveyed for value to an unrelated entity less than five years after the effective date of such rate increase, the rate increase shall be deemed rescinded and the department shall recover an amount equal to the difference between payments made for all affected rate periods and payments that would have been made if the interim rate increase was not granted. The commissioner may seek recovery from payments made to any facility with common ownership. With the approval of the Secretary of the Office of Policy and Management, the commissioner may waive recovery and rescission of the interim rate for good cause shown that is not inconsistent with this section, including, but not limited to, transfers to family members that were made for no value. The commissioner shall provide written quarterly reports to the joint standing committees of the General Assembly having cognizance of matters relating to human services and appropriations and the budgets of state agencies and to the select committee of the General Assembly having cognizance of matters relating to aging, that identify each facility requesting an interim rate increase, the amount of the requested rate increase for each facility, the action taken by the commissioner and the secretary pursuant to this subsection, and estimates of the additional cost to the state for each approved interim rate increase. Nothing in this subsection shall prohibit the commissioner from increasing the rate of a licensed chronic and convalescent nursing home or a rest home with nursing supervision for allowable costs associated with facility capital improvements or increasing the rate in case of a sale of a licensed chronic and convalescent nursing home or a rest home with nursing supervision, pursuant to subdivision (15) of subsection (f) of this section, if receivership has been imposed on such home.

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(b) The Commissioner of Social Services shall adopt regulations in accordance with the provisions of chapter 54 to specify other allowable services. For purposes of this section, other allowable services means those services required by any medical assistance beneficiary residing in such home or hospital which are not already covered in the rate set by the commissioner in accordance with the provisions of subsection (a) of this section.

(c) No facility subject to the requirements of this section shall accept payment in excess of the rate set by the commissioner pursuant to subsection (a) of this section for any medical assistance patient from this or any other state. No facility shall accept payment in excess of the reasonable and necessary costs of other allowable services as specified by the commissioner pursuant to the regulations adopted under subsection (b) of this section for any public assistance patient from this or any other state. Notwithstanding the provisions of this subsection, the commissioner may authorize a facility to accept payment in excess of the rate paid for a medical assistance patient in this state for a patient who receives medical assistance from another state.

(d) In any instance where the Commissioner of Social Services finds that a facility subject to the requirements of this section is accepting payment for a medical assistance beneficiary in violation of subsection (c) of this section, the commissioner shall proceed to recover through the rate set for the facility any sum in excess of the stipulated per diem and other allowable costs, as provided for in regulations adopted pursuant to subsections (a) and (b) of this section. The commissioner shall make the recovery prospectively at the time of the next annual rate redetermination.

(e) Except as provided in this subsection, the provisions of subsections (c) and (d) of this section shall not apply to any facility subject to the requirements of this section, which on October 1, 1981, (1) was accepting payments from the commissioner in accordance with

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the provisions of subsection (a) of this section, (2) was accepting medical assistance payments from another state for at least twenty per cent of its patients, and (3) had not notified the commissioner of any intent to terminate its provider agreement, in accordance with section 17b-271, provided no patient residing in any such facility on May 22, 1984, shall be removed from such facility for purposes of meeting the requirements of this subsection. If the commissioner finds that the number of beds available to medical assistance patients from this state in any such facility is less than fifteen per cent the provisions of subsections (c) and (d) of this section shall apply to that number of beds which is less than said percentage.

(f) For the fiscal year ending June 30, 1992, the rates paid by or for persons aided or cared for by the state or any town in this state to facilities for room, board and services specified in licensing regulations issued by the licensing agency, except intermediate care facilities for [the mentally retarded] individuals with intellectual disabilities and residential care homes, shall be based on the cost year ending September 30, 1989. For the fiscal years ending June 30, 1993, and June 30, 1994, such rates shall be based on the cost year ending September 30, 1990. Such rates shall be determined by the Commissioner of Social Services in accordance with this section and the regulations of Connecticut state agencies promulgated by the commissioner and in effect on April 1, 1991, except that:

(1) Allowable costs shall be divided into the following five cost components: Direct costs, which shall include salaries for nursing personnel, related fringe benefits and nursing pool costs; indirect costs, which shall include professional fees, dietary expenses, housekeeping expenses, laundry expenses, supplies related to patient care, salaries for indirect care personnel and related fringe benefits; fair rent, which shall be defined in accordance with subsection (f) of section 17-311-52 of the regulations of Connecticut state agencies; capital-related costs,

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which shall include property taxes, insurance expenses, equipment leases and equipment depreciation; and administrative and general costs, which shall include maintenance and operation of plant expenses, salaries for administrative and maintenance personnel and related fringe benefits. The commissioner may provide a rate adjustment for nonemergency transportation services required by nursing facility residents. Such adjustment shall be a fixed amount determined annually by the commissioner based upon a review of costs and other associated information. Allowable costs shall not include costs for ancillary services payable under Part B of the Medicare program.

(2) Two geographic peer groupings of facilities shall be established for each level of care, as defined by the Department of Social Services for the determination of rates, for the purpose of determining allowable direct costs. One peer grouping shall be comprised of those facilities located in Fairfield County. The other peer grouping shall be comprised of facilities located in all other counties.

(3) For the fiscal year ending June 30, 1992, per diem maximum allowable costs for each cost component shall be as follows: For direct costs, the maximum shall be equal to one hundred forty per cent of the median allowable cost of that peer grouping; for indirect costs, the maximum shall be equal to one hundred thirty per cent of the state-wide median allowable cost; for fair rent, the amount shall be calculated utilizing the amount approved by the Office of Health Care Access pursuant to section 19a-638, as amended by this act; for capital-related costs, there shall be no maximum; and for administrative and general costs, the maximum shall be equal to one hundred twenty-five per cent of the state-wide median allowable cost. For the fiscal year ending June 30, 1993, per diem maximum allowable costs for each cost component shall be as follows: For direct costs, the maximum shall be equal to one hundred forty per cent of the median allowable cost of

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that peer grouping; for indirect costs, the maximum shall be equal to one hundred twenty-five per cent of the state-wide median allowable cost; for fair rent, the amount shall be calculated utilizing the amount approved by the Office of Health Care Access pursuant to section 19a-638, as amended by this act; for capital-related costs, there shall be no maximum; and for administrative and general costs the maximum shall be equal to one hundred fifteen per cent of the state-wide median allowable cost. For the fiscal year ending June 30, 1994, per diem maximum allowable costs for each cost component shall be as follows: For direct costs, the maximum shall be equal to one hundred thirty-five per cent of the median allowable cost of that peer grouping; for indirect costs, the maximum shall be equal to one hundred twenty per cent of the state-wide median allowable cost; for fair rent, the amount shall be calculated utilizing the amount approved by the Office of Health Care Access pursuant to section 19a-638, as amended by this act; for capital-related costs, there shall be no maximum; and for administrative and general costs the maximum shall be equal to one hundred ten per cent of the state-wide median allowable cost. For the fiscal year ending June 30, 1995, per diem maximum allowable costs for each cost component shall be as follows: For direct costs, the maximum shall be equal to one hundred thirty-five per cent of the median allowable cost of that peer grouping; for indirect costs, the maximum shall be equal to one hundred twenty per cent of the state-wide median allowable cost; for fair rent, the amount shall be calculated utilizing the amount approved by the Office of Health Care Access pursuant to section 19a-638, as amended by this act; for capital-related costs, there shall be no maximum; and for administrative and general costs the maximum shall be equal to one hundred five per cent of the state-wide median allowable cost. For the fiscal year ending June 30, 1996, and any succeeding fiscal year, except for the fiscal years ending June 30, 2000, and June 30, 2001, for facilities with an interim rate in one or both periods, per diem maximum allowable costs for each cost component shall be as follows: For direct costs, the maximum

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shall be equal to one hundred thirty-five per cent of the median allowable cost of that peer grouping; for indirect costs, the maximum shall be equal to one hundred fifteen per cent of the state-wide median allowable cost; for fair rent, the amount shall be calculated utilizing the amount approved pursuant to section 19a-638, as amended by this act; for capital-related costs, there shall be no maximum; and for administrative and general costs the maximum shall be equal to the state-wide median allowable cost. For the fiscal years ending June 30, 2000, and June 30, 2001, for facilities with an interim rate in one or both periods, per diem maximum allowable costs for each cost component shall be as follows: For direct costs, the maximum shall be equal to one hundred forty-five per cent of the median allowable cost of that peer grouping; for indirect costs, the maximum shall be equal to one hundred twenty-five per cent of the state-wide median allowable cost; for fair rent, the amount shall be calculated utilizing the amount approved pursuant to section 19a-638, as amended by this act; for capital-related costs, there shall be no maximum; and for administrative and general costs, the maximum shall be equal to the state-wide median allowable cost and such medians shall be based upon the same cost year used to set rates for facilities with prospective rates. Costs in excess of the maximum amounts established under this subsection shall not be recognized as allowable costs, except that the Commissioner of Social Services (A) may allow costs in excess of maximum amounts for any facility with patient days covered by Medicare, including days requiring coinsurance, in excess of twelve per cent of annual patient days which also has patient days covered by Medicaid in excess of fifty per cent of annual patient days; (B) may establish a pilot program whereby costs in excess of maximum amounts shall be allowed for beds in a nursing home which has a managed care program and is affiliated with a hospital licensed under chapter 368v; and (C) may establish rates whereby allowable costs may exceed such maximum amounts for beds approved on or after July 1, 1991, which are restricted to use by patients with acquired immune

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deficiency syndrome or traumatic brain injury.

(4) For the fiscal year ending June 30, 1992, (A) no facility shall receive a rate that is less than the rate it received for the rate year ending June 30, 1991; (B) no facility whose rate, if determined pursuant to this subsection, would exceed one hundred twenty per cent of the state-wide median rate, as determined pursuant to this subsection, shall receive a rate which is five and one-half per cent more than the rate it received for the rate year ending June 30, 1991; and (C) no facility whose rate, if determined pursuant to this subsection, would be less than one hundred twenty per cent of the state-wide median rate, as determined pursuant to this subsection, shall receive a rate which is six and one-half per cent more than the rate it received for the rate year ending June 30, 1991. For the fiscal year ending June 30, 1993, no facility shall receive a rate that is less than the rate it received for the rate year ending June 30, 1992, or six per cent more than the rate it received for the rate year ending June 30, 1992. For the fiscal year ending June 30, 1994, no facility shall receive a rate that is less than the rate it received for the rate year ending June 30, 1993, or six per cent more than the rate it received for the rate year ending June 30, 1993. For the fiscal year ending June 30, 1995, no facility shall receive a rate that is more than five per cent less than the rate it received for the rate year ending June 30, 1994, or six per cent more than the rate it received for the rate year ending June 30, 1994. For the fiscal years ending June 30, 1996, and June 30, 1997, no facility shall receive a rate that is more than three per cent more than the rate it received for the prior rate year. For the fiscal year ending June 30, 1998, a facility shall receive a rate increase that is not more than two per cent more than the rate that the facility received in the prior year. For the fiscal year ending June 30, 1999, a facility shall receive a rate increase that is not more than three per cent more than the rate that the facility received in the prior year and that is not less than one per cent more than the rate that the facility received in the prior year, exclusive of rate increases associated

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with a wage, benefit and staffing enhancement rate adjustment added for the period from April 1, 1999, to June 30, 1999, inclusive. For the fiscal year ending June 30, 2000, each facility, except a facility with an interim rate or replaced interim rate for the fiscal year ending June 30, 1999, and a facility having a certificate of need or other agreement specifying rate adjustments for the fiscal year ending June 30, 2000, shall receive a rate increase equal to one per cent applied to the rate the facility received for the fiscal year ending June 30, 1999, exclusive of the facility's wage, benefit and staffing enhancement rate adjustment. For the fiscal year ending June 30, 2000, no facility with an interim rate, replaced interim rate or scheduled rate adjustment specified in a certificate of need or other agreement for the fiscal year ending June 30, 2000, shall receive a rate increase that is more than one per cent more than the rate the facility received in the fiscal year ending June 30, 1999. For the fiscal year ending June 30, 2001, each facility, except a facility with an interim rate or replaced interim rate for the fiscal year ending June 30, 2000, and a facility having a certificate of need or other agreement specifying rate adjustments for the fiscal year ending June 30, 2001, shall receive a rate increase equal to two per cent applied to the rate the facility received for the fiscal year ending June 30, 2000, subject to verification of wage enhancement adjustments pursuant to subdivision (14) of this subsection. For the fiscal year ending June 30, 2001, no facility with an interim rate, replaced interim rate or scheduled rate adjustment specified in a certificate of need or other agreement for the fiscal year ending June 30, 2001, shall receive a rate increase that is more than two per cent more than the rate the facility received for the fiscal year ending June 30, 2000. For the fiscal year ending June 30, 2002, each facility shall receive a rate that is two and one-half per cent more than the rate the facility received in the prior fiscal year. For the fiscal year ending June 30, 2003, each facility shall receive a rate that is two per cent more than the rate the facility received in the prior fiscal year, except that such increase shall be effective January 1, 2003, and such facility rate in effect for the fiscal

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year ending June 30, 2002, shall be paid for services provided until December 31, 2002, except any facility that would have been issued a lower rate effective July 1, 2002, than for the fiscal year ending June 30, 2002, due to interim rate status or agreement with the department shall be issued such lower rate effective July 1, 2002, and have such rate increased two per cent effective June 1, 2003. For the fiscal year ending June 30, 2004, rates in effect for the period ending June 30, 2003, shall remain in effect, except any facility that would have been issued a lower rate effective July 1, 2003, than for the fiscal year ending June 30, 2003, due to interim rate status or agreement with the department shall be issued such lower rate effective July 1, 2003. For the fiscal year ending June 30, 2005, rates in effect for the period ending June 30, 2004, shall remain in effect until December 31, 2004, except any facility that would have been issued a lower rate effective July 1, 2004, than for the fiscal year ending June 30, 2004, due to interim rate status or agreement with the department shall be issued such lower rate effective July 1, 2004. Effective January 1, 2005, each facility shall receive a rate that is one per cent greater than the rate in effect December 31, 2004. Effective upon receipt of all the necessary federal approvals to secure federal financial participation matching funds associated with the rate increase provided in this subdivision, but in no event earlier than July 1, 2005, and provided the user fee imposed under section 17b-320 is required to be collected, for the fiscal year ending June 30, 2006, the department shall compute the rate for each facility based upon its 2003 cost report filing or a subsequent cost year filing for facilities having an interim rate for the period ending June 30, 2005, as provided under section 17-311-55 of the regulations of Connecticut state agencies. For each facility not having an interim rate for the period ending June 30, 2005, the rate for the period ending June 30, 2006, shall be determined beginning with the higher of the computed rate based upon its 2003 cost report filing or the rate in effect for the period ending June 30, 2005. Such rate shall then be increased by eleven dollars and eighty cents per day except that in no

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event shall the rate for the period ending June 30, 2006, be thirty-two dollars more than the rate in effect for the period ending June 30, 2005, and for any facility with a rate below one hundred ninety-five dollars per day for the period ending June 30, 2005, such rate for the period ending June 30, 2006, shall not be greater than two hundred seventeen dollars and forty-three cents per day and for any facility with a rate equal to or greater than one hundred ninety-five dollars per day for the period ending June 30, 2005, such rate for the period ending June 30, 2006, shall not exceed the rate in effect for the period ending June 30, 2005, increased by eleven and one-half per cent. For each facility with an interim rate for the period ending June 30, 2005, the interim replacement rate for the period ending June 30, 2006, shall not exceed the rate in effect for the period ending June 30, 2005, increased by eleven dollars and eighty cents per day plus the per day cost of the user fee payments made pursuant to section 17b-320 divided by annual resident service days, except for any facility with an interim rate below one hundred ninety-five dollars per day for the period ending June 30, 2005, the interim replacement rate for the period ending June 30, 2006, shall not be greater than two hundred seventeen dollars and forty-three cents per day and for any facility with an interim rate equal to or greater than one hundred ninety-five dollars per day for the period ending June 30, 2005, the interim replacement rate for the period ending June 30, 2006, shall not exceed the rate in effect for the period ending June 30, 2005, increased by eleven and one-half per cent. Such July 1, 2005, rate adjustments shall remain in effect unless (i) the federal financial participation matching funds associated with the rate increase are no longer available; or (ii) the user fee created pursuant to section 17b-320 is not in effect. For the fiscal year ending June 30, 2007, each facility shall receive a rate that is three per cent greater than the rate in effect for the period ending June 30, 2006, except any facility that would have been issued a lower rate effective July 1, 2006, than for the rate period ending June 30, 2006, due to interim rate status or agreement with the department, shall be issued

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such lower rate effective July 1, 2006. For the fiscal year ending June 30, 2008, each facility shall receive a rate that is two and nine-tenths per cent greater than the rate in effect for the period ending June 30, 2007, except any facility that would have been issued a lower rate effective July 1, 2007, than for the rate period ending June 30, 2007, due to interim rate status or agreement with the department, shall be issued such lower rate effective July 1, 2007. For the fiscal year ending June 30, 2009, rates in effect for the period ending June 30, 2008, shall remain in effect until June 30, 2009, except any facility that would have been issued a lower rate for the fiscal year ending June 30, 2009, due to interim rate status or agreement with the department shall be issued such lower rate. For the fiscal years ending June 30, 2010, and June 30, 2011, rates in effect for the period ending June 30, 2009, shall remain in effect until June 30, 2011, except any facility that would have been issued a lower rate for the fiscal year ending June 30, 2010, or the fiscal year ending June 30, 2011, due to interim rate status or agreement with the department, shall be issued such lower rate. For the fiscal years ending June 30, 2012, and June 30, 2013, rates in effect for the period ending June 30, 2011, shall remain in effect until June 30, 2013, except any facility that would have been issued a lower rate for the fiscal year ending June 30, 2012, or the fiscal year ending June 30, 2013, due to interim rate status or agreement with the department, shall be issued such lower rate. The Commissioner of Social Services shall add fair rent increases to any other rate increases established pursuant to this subdivision for a facility which has undergone a material change in circumstances related to fair rent, except for the fiscal years ending June 30, 2010, June 30, 2011, and June 30, 2012, such fair rent increases shall only be provided to facilities with an approved certificate of need pursuant to section 17b-352, as amended by this act, 17b-353, 17b-354 or 17b-355. For the fiscal year ending June 30, 2013, the commissioner may, within available appropriations, provide pro rata fair rent increases for facilities which have undergone a material change in circumstances related to fair rent additions placed in service in cost

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report years ending September 30, 2008, to September 30, 2011, inclusive, and not otherwise included in rates issued. For the fiscal year ending June 30, 2013, the commissioner shall add fair rent increases associated with an approved certificate of need pursuant to section 17b-352, as amended by this act, 17b-353, 17b-354 or 17b-355. Interim rates may take into account reasonable costs incurred by a facility, including wages and benefits. Notwithstanding the provisions of this section, the Commissioner of Social Services may, within available appropriations, increase rates issued to licensed chronic and convalescent nursing homes and licensed rest homes with nursing supervision.

(5) For the purpose of determining allowable fair rent, a facility with allowable fair rent less than the twenty-fifth percentile of the state-wide allowable fair rent shall be reimbursed as having allowable fair rent equal to the twenty-fifth percentile of the state-wide allowable fair rent, provided for the fiscal years ending June 30, 1996, and June 30, 1997, the reimbursement may not exceed the twenty-fifth percentile of the state-wide allowable fair rent for the fiscal year ending June 30, 1995. On and after July 1, 1998, the Commissioner of Social Services may allow minimum fair rent as the basis upon which reimbursement associated with improvements to real property is added. Beginning with the fiscal year ending June 30, 1996, any facility with a rate of return on real property other than land in excess of eleven per cent shall have such allowance revised to eleven per cent. Any facility or its related realty affiliate which finances or refinances debt through bonds issued by the State of Connecticut Health and Education Facilities Authority shall report the terms and conditions of such financing or refinancing to the Commissioner of Social Services within thirty days of completing such financing or refinancing. The Commissioner of Social Services may revise the facility's fair rent component of its rate to reflect any financial benefit the facility or its related realty affiliate received as a result of such financing or refinancing, including but not

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limited to, reductions in the amount of debt service payments or period of debt repayment. The commissioner shall allow actual debt service costs for bonds issued by the State of Connecticut Health and Educational Facilities Authority if such costs do not exceed property costs allowed pursuant to subsection (f) of section 17-311-52 of the regulations of Connecticut state agencies, provided the commissioner may allow higher debt service costs for such bonds for good cause. For facilities which first open on or after October 1, 1992, the commissioner shall determine allowable fair rent for real property other than land based on the rate of return for the cost year in which such bonds were issued. The financial benefit resulting from a facility financing or refinancing debt through such bonds shall be shared between the state and the facility to an extent determined by the commissioner on a case-by-case basis and shall be reflected in an adjustment to the facility's allowable fair rent.

(6) A facility shall receive cost efficiency adjustments for indirect costs and for administrative and general costs if such costs are below the state-wide median costs. The cost efficiency adjustments shall equal twenty-five per cent of the difference between allowable reported costs and the applicable median allowable cost established pursuant to this subdivision.

(7) For the fiscal year ending June 30, 1992, allowable operating costs, excluding fair rent, shall be inflated using the Regional Data Resources Incorporated McGraw-Hill Health Care Costs: Consumer Price Index (all urban)-All Items minus one and one-half per cent. For the fiscal year ending June 30, 1993, allowable operating costs, excluding fair rent, shall be inflated using the Regional Data Resources Incorporated McGraw-Hill Health Care Costs: Consumer Price Index (all urban)-All Items minus one and three-quarters per cent. For the fiscal years ending June 30, 1994, and June 30, 1995, allowable operating costs, excluding fair rent, shall be inflated using the Regional

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Data Resources Incorporated McGraw-Hill Health Care Costs: Consumer Price Index (all urban)-All Items minus two per cent. For the fiscal year ending June 30, 1996, allowable operating costs, excluding fair rent, shall be inflated using the Regional Data Resources Incorporated McGraw-Hill Health Care Costs: Consumer Price Index (all urban)-All Items minus two and one-half per cent. For the fiscal year ending June 30, 1997, allowable operating costs, excluding fair rent, shall be inflated using the Regional Data Resources Incorporated McGraw-Hill Health Care Costs: Consumer Price Index (all urban)-All Items minus three and one-half per cent. For the fiscal year ending June 30, 1992, and any succeeding fiscal year, allowable fair rent shall be those reported in the annual report of long-term care facilities for the cost year ending the immediately preceding September thirtieth. The inflation index to be used pursuant to this subsection shall be computed to reflect inflation between the midpoint of the cost year through the midpoint of the rate year. The Department of Social Services shall study methods of reimbursement for fair rent and shall report its findings and recommendations to the joint standing committee of the General Assembly having cognizance of matters relating to human services on or before January 15, 1993.

(8) On and after July 1, 1994, costs shall be rebased no more frequently than every two years and no less frequently than every four years, as determined by the commissioner. The commissioner shall determine whether and to what extent a change in ownership of a facility shall occasion the rebasing of the facility's costs.

(9) The method of establishing rates for new facilities shall be determined by the commissioner in accordance with the provisions of this subsection.

(10) Rates determined under this section shall comply with federal laws and regulations.

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(11) Notwithstanding the provisions of this subsection, interim rates issued for facilities on and after July 1, 1991, shall be subject to applicable fiscal year cost component limitations established pursuant to subdivision (3) of this subsection.

(12) A chronic and convalescent nursing home having an ownership affiliation with and operated at the same location as a chronic disease hospital may request that the commissioner approve an exception to applicable rate-setting provisions for chronic and convalescent nursing homes and establish a rate for the fiscal years ending June 30, 1992, and June 30, 1993, in accordance with regulations in effect June 30, 1991. Any such rate shall not exceed one hundred sixty-five per cent of the median rate established for chronic and convalescent nursing homes established under this section for the applicable fiscal year.

(13) For the fiscal year ending June 30, 1994, and any succeeding fiscal year, for purposes of computing minimum allowable patient days, utilization of a facility's certified beds shall be determined at a minimum of ninety-five per cent of capacity, except for new facilities and facilities which are certified for additional beds which may be permitted a lower occupancy rate for the first three months of operation after the effective date of licensure.

(14) The Commissioner of Social Services shall adjust facility rates from April 1, 1999, to June 30, 1999, inclusive, by a per diem amount representing each facility's allocation of funds appropriated for the purpose of wage, benefit and staffing enhancement. A facility's per diem allocation of such funding shall be computed as follows: (A) The facility's direct and indirect component salary, wage, nursing pool and allocated fringe benefit costs as filed for the 1998 cost report period deemed allowable in accordance with this section and applicable regulations without application of cost component maximums specified in subdivision (3) of this subsection shall be totalled; (B) such total shall be multiplied by the facility's Medicaid utilization based on

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the 1998 cost report; (C) the resulting amount for the facility shall be divided by the sum of the calculations specified in subparagraphs (A) and (B) of this subdivision for all facilities to determine the facility's percentage share of appropriated wage, benefit and staffing enhancement funding; (D) the facility's percentage share shall be multiplied by the amount of appropriated wage, benefit and staffing enhancement funding to determine the facility's allocated amount; and (E) such allocated amount shall be divided by the number of days of care paid for by Medicaid on an annual basis including days for reserved beds specified in the 1998 cost report to determine the per diem wage and benefit rate adjustment amount. The commissioner may adjust a facility's reported 1998 cost and utilization data for the purposes of determining a facility's share of wage, benefit and staffing enhancement funding when reported 1998 information is not substantially representative of estimated cost and utilization data for the fiscal year ending June 30, 2000, due to special circumstances during the 1998 cost report period including change of ownership with a part year cost filing or reductions in facility capacity due to facility renovation projects. Upon completion of the calculation of the allocation of wage, benefit and staffing enhancement funding, the commissioner shall not adjust the allocations due to revisions submitted to previously filed 1998 annual cost reports. In the event that a facility's rate for the fiscal year ending June 30, 1999, is an interim rate or the rate includes an increase adjustment due to a rate request to the commissioner or other reasons, the commissioner may reduce or withhold the per diem wage, benefit and staffing enhancement allocation computed for the facility. Any enhancement allocations not applied to facility rates shall not be reallocated to other facilities and such unallocated amounts shall be available for the costs associated with interim rates and other Medicaid expenditures. The wage, benefit and staffing enhancement per diem adjustment for the period from April 1, 1999, to June 30, 1999, inclusive, shall also be applied to rates for the fiscal years ending June 30, 2000, and June 30,

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2001, except that the commissioner may increase or decrease the adjustment to account for changes in facility capacity or operations. Any facility accepting a rate adjustment for wage, benefit and staffing enhancements shall apply payments made as a result of such rate adjustment for increased allowable employee wage rates and benefits and additional direct and indirect component staffing. Adjustment funding shall not be applied to wage and salary increases provided to the administrator, assistant administrator, owners or related party employees. Enhancement payments may be applied to increases in costs associated with staffing purchased from staffing agencies provided such costs are deemed necessary and reasonable by the commissioner. The commissioner shall compare expenditures for wages, benefits and staffing for the 1998 cost report period to such expenditures in the 1999, 2000 and 2001 cost report periods to verify whether a facility has applied additional payments to specified enhancements. In the event that the commissioner determines that a facility did not apply additional payments to specified enhancements, the commissioner shall recover such amounts from the facility through rate adjustments or other means. The commissioner may require facilities to file cost reporting forms, in addition to the annual cost report, as may be necessary, to verify the appropriate application of wage, benefit and staffing enhancement rate adjustment payments. For the purposes of this subdivision, "Medicaid utilization" means the number of days of care paid for by Medicaid on an annual basis including days for reserved beds as a percentage of total resident days.

(15) The interim rate established to become effective upon sale of any licensed chronic and convalescent home or rest home with nursing supervision for which a receivership has been imposed pursuant to sections 19a-541 to 19a-549, inclusive, shall not exceed the rate in effect for the facility at the time of the imposition of the receivership, subject to any annual increases permitted by this section; provided the Commissioner of Social Services may, in the commissioner's discretion,

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and after consultation with the receiver, establish an increased rate for the facility if the commissioner with approval of the Secretary of the Office of Policy and Management determines that such higher rate is needed to keep the facility open and to ensure the health, safety and welfare of the residents at such facility.

(g) For the fiscal year ending June 30, 1993, any intermediate care facility for [the mentally retarded] individuals with intellectual disabilities with an operating cost component of its rate in excess of one hundred forty per cent of the median of operating cost components of rates in effect January 1, 1992, shall not receive an operating cost component increase. For the fiscal year ending June 30, 1993, any intermediate care facility for [the mentally retarded] individuals with intellectual disabilities with an operating cost component of its rate that is less than one hundred forty per cent of the median of operating cost components of rates in effect January 1, 1992, shall have an allowance for real wage growth equal to thirty per cent of the increase determined in accordance with subsection (q) of section 17-311-52 of the regulations of Connecticut state agencies, provided such operating cost component shall not exceed one hundred forty per cent of the median of operating cost components in effect January 1, 1992. Any facility with real property other than land placed in service prior to October 1, 1991, shall, for the fiscal year ending June 30, 1995, receive a rate of return on real property equal to the average of the rates of return applied to real property other than land placed in service for the five years preceding October 1, 1993. For the fiscal year ending June 30, 1996, and any succeeding fiscal year, the rate of return on real property for property items shall be revised every five years. The commissioner shall, upon submission of a request, allow actual debt service, comprised of principal and interest, in excess of property costs allowed pursuant to section 17-311-52 of the regulations of Connecticut state agencies, provided such debt service terms and amounts are reasonable in relation to the useful life and the base value

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of the property. For the fiscal year ending June 30, 1995, and any succeeding fiscal year, the inflation adjustment made in accordance with subsection (p) of section 17-311-52 of the regulations of Connecticut state agencies shall not be applied to real property costs. For the fiscal year ending June 30, 1996, and any succeeding fiscal year, the allowance for real wage growth, as determined in accordance with subsection (q) of section 17-311-52 of the regulations of Connecticut state agencies, shall not be applied. For the fiscal year ending June 30, 1996, and any succeeding fiscal year, no rate shall exceed three hundred seventy-five dollars per day unless the commissioner, in consultation with the Commissioner of Developmental Services, determines after a review of program and management costs, that a rate in excess of this amount is necessary for care and treatment of facility residents. For the fiscal year ending June 30, 2002, rate period, the Commissioner of Social Services shall increase the inflation adjustment for rates made in accordance with subsection (p) of section 17-311-52 of the regulations of Connecticut state agencies to update allowable fiscal year 2000 costs to include a three and one-half per cent inflation factor. For the fiscal year ending June 30, 2003, rate period, the commissioner shall increase the inflation adjustment for rates made in accordance with subsection (p) of section 17-311-52 of the regulations of Connecticut state agencies to update allowable fiscal year 2001 costs to include a one and one-half per cent inflation factor, except that such increase shall be effective November 1, 2002, and such facility rate in effect for the fiscal year ending June 30, 2002, shall be paid for services provided until October 31, 2002, except any facility that would have been issued a lower rate effective July 1, 2002, than for the fiscal year ending June 30, 2002, due to interim rate status or agreement with the department shall be issued such lower rate effective July 1, 2002, and have such rate updated effective November 1, 2002, in accordance with applicable statutes and regulations. For the fiscal year ending June 30, 2004, rates in effect for the period ending June 30, 2003, shall remain in effect, except any facility that would have been issued a lower rate

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effective July 1, 2003, than for the fiscal year ending June 30, 2003, due to interim rate status or agreement with the department shall be issued such lower rate effective July 1, 2003. For the fiscal year ending June 30, 2005, rates in effect for the period ending June 30, 2004, shall remain in effect until September 30, 2004. Effective October 1, 2004, each facility shall receive a rate that is five per cent greater than the rate in effect September 30, 2004. Effective upon receipt of all the necessary federal approvals to secure federal financial participation matching funds associated with the rate increase provided in subdivision (4) of subsection (f) of this section, but in no event earlier than October 1, 2005, and provided the user fee imposed under section 17b-320 is required to be collected, each facility shall receive a rate that is four per cent more than the rate the facility received in the prior fiscal year, except any facility that would have been issued a lower rate effective October 1, 2005, than for the fiscal year ending June 30, 2005, due to interim rate status or agreement with the department, shall be issued such lower rate effective October 1, 2005. Such rate increase shall remain in effect unless: (1) The federal financial participation matching funds associated with the rate increase are no longer available; or (2) the user fee created pursuant to section 17b-320 is not in effect. For the fiscal year ending June 30, 2007, rates in effect for the period ending June 30, 2006, shall remain in effect until September 30, 2006, except any facility that would have been issued a lower rate effective July 1, 2006, than for the fiscal year ending June 30, 2006, due to interim rate status or agreement with the department, shall be issued such lower rate effective July 1, 2006. Effective October 1, 2006, no facility shall receive a rate that is more than three per cent greater than the rate in effect for the facility on September 30, 2006, except any facility that would have been issued a lower rate effective October 1, 2006, due to interim rate status or agreement with the department, shall be issued such lower rate effective October 1, 2006. For the fiscal year ending June 30, 2008, each facility shall receive a rate that is two and nine-tenths per cent greater than the rate in effect for the period

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ending June 30, 2007, except any facility that would have been issued a lower rate effective July 1, 2007, than for the rate period ending June 30, 2007, due to interim rate status, or agreement with the department, shall be issued such lower rate effective July 1, 2007. For the fiscal year ending June 30, 2009, rates in effect for the period ending June 30, 2008, shall remain in effect until June 30, 2009, except any facility that would have been issued a lower rate for the fiscal year ending June 30, 2009, due to interim rate status or agreement with the department, shall be issued such lower rate. For the fiscal years ending June 30, 2010, and June 30, 2011, rates in effect for the period ending June 30, 2009, shall remain in effect until June 30, 2011, except any facility that would have been issued a lower rate for the fiscal year ending June 30, 2010, or the fiscal year ending June 30, 2011, due to interim rate status or agreement with the department, shall be issued such lower rate. For the fiscal year ending June 30, 2012, rates in effect for the period ending June 30, 2011, shall remain in effect until June 30, 2012, except any facility that would have been issued a lower rate for the fiscal year ending June 30, 2012, due to interim rate status or agreement with the department, shall be issued such lower rate. For the fiscal year ending June 30, 2013, any facility that has a significant decrease in land and building costs shall receive a reduced rate to reflect such decrease in land and building costs. For the fiscal years ending June 30, 2012, and June 30, 2013, the Commissioner of Social Services may provide fair rent increases to any facility that has undergone a material change in circumstances related to fair rent and has an approved certificate of need pursuant to section 17b-352, as amended by this act, 17b-353, 17b-354 or 17b-355. Notwithstanding the provisions of this section, the Commissioner of Social Services may, within available appropriations, increase rates issued to intermediate care facilities for [the mentally retarded] individuals with intellectual disabilities.

(h) (1) For the fiscal year ending June 30, 1993, any residential care home with an operating cost component of its rate in excess of one

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hundred thirty per cent of the median of operating cost components of rates in effect January 1, 1992, shall not receive an operating cost component increase. For the fiscal year ending June 30, 1993, any residential care home with an operating cost component of its rate that is less than one hundred thirty per cent of the median of operating cost components of rates in effect January 1, 1992, shall have an allowance for real wage growth equal to sixty-five per cent of the increase determined in accordance with subsection (q) of section 17-311-52 of the regulations of Connecticut state agencies, provided such operating cost component shall not exceed one hundred thirty per cent of the median of operating cost components in effect January 1, 1992. Beginning with the fiscal year ending June 30, 1993, for the purpose of determining allowable fair rent, a residential care home with allowable fair rent less than the twenty-fifth percentile of the state-wide allowable fair rent shall be reimbursed as having allowable fair rent equal to the twenty-fifth percentile of the state-wide allowable fair rent. Beginning with the fiscal year ending June 30, 1997, a residential care home with allowable fair rent less than three dollars and ten cents per day shall be reimbursed as having allowable fair rent equal to three dollars and ten cents per day. Property additions placed in service during the cost year ending September 30, 1996, or any succeeding cost year shall receive a fair rent allowance for such additions as an addition to three dollars and ten cents per day if the fair rent for the facility for property placed in service prior to September 30, 1995, is less than or equal to three dollars and ten cents per day. For the fiscal year ending June 30, 1996, and any succeeding fiscal year, the allowance for real wage growth, as determined in accordance with subsection (q) of section 17-311-52 of the regulations of Connecticut state agencies, shall not be applied. For the fiscal year ending June 30, 1996, and any succeeding fiscal year, the inflation adjustment made in accordance with subsection (p) of section 17-311-52 of the regulations of Connecticut state agencies shall not be applied to real property costs. Beginning with the fiscal year ending June 30,

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1997, minimum allowable patient days for rate computation purposes for a residential care home with twenty-five beds or less shall be eighty-five per cent of licensed capacity. Beginning with the fiscal year ending June 30, 2002, for the purposes of determining the allowable salary of an administrator of a residential care home with sixty beds or less the department shall revise the allowable base salary to thirty-seven thousand dollars to be annually inflated thereafter in accordance with section 17-311-52 of the regulations of Connecticut state agencies. The rates for the fiscal year ending June 30, 2002, shall be based upon the increased allowable salary of an administrator, regardless of whether such amount was expended in the 2000 cost report period upon which the rates are based. Beginning with the fiscal year ending June 30, 2000, and until the fiscal year ending June 30, 2009, inclusive, the inflation adjustment for rates made in accordance with subsection (p) of section 17-311-52 of the regulations of Connecticut state agencies shall be increased by two per cent, and beginning with the fiscal year ending June 30, 2002, the inflation adjustment for rates made in accordance with subsection (c) of said section shall be increased by one per cent. Beginning with the fiscal year ending June 30, 1999, for the purpose of determining the allowable salary of a related party, the department shall revise the maximum salary to twenty-seven thousand eight hundred fifty-six dollars to be annually inflated thereafter in accordance with section 17-311-52 of the regulations of Connecticut state agencies and beginning with the fiscal year ending June 30, 2001, such allowable salary shall be computed on an hourly basis and the maximum number of hours allowed for a related party other than the proprietor shall be increased from forty hours to forty-eight hours per work week. For the fiscal year ending June 30, 2005, each facility shall receive a rate that is two and one-quarter per cent more than the rate the facility received in the prior fiscal year, except any facility that would have been issued a lower rate effective July 1, 2004, than for the fiscal year ending June 30, 2004, due to interim rate status or agreement with the department shall be issued such lower

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rate effective July 1, 2004. Effective upon receipt of all the necessary federal approvals to secure federal financial participation matching funds associated with the rate increase provided in subdivision (4) of subsection (f) of this section, but in no event earlier than October 1, 2005, and provided the user fee imposed under section 17b-320 is required to be collected, each facility shall receive a rate that is determined in accordance with applicable law and subject to appropriations, except any facility that would have been issued a lower rate effective October 1, 2005, than for the fiscal year ending June 30, 2005, due to interim rate status or agreement with the department, shall be issued such lower rate effective October 1, 2005. Such rate increase shall remain in effect unless: (A) The federal financial participation matching funds associated with the rate increase are no longer available; or (B) the user fee created pursuant to section 17b-320 is not in effect. For the fiscal year ending June 30, 2007, rates in effect for the period ending June 30, 2006, shall remain in effect until September 30, 2006, except any facility that would have been issued a lower rate effective July 1, 2006, than for the fiscal year ending June 30, 2006, due to interim rate status or agreement with the department, shall be issued such lower rate effective July 1, 2006. Effective October 1, 2006, no facility shall receive a rate that is more than four per cent greater than the rate in effect for the facility on September 30, 2006, except for any facility that would have been issued a lower rate effective October 1, 2006, due to interim rate status or agreement with the department, shall be issued such lower rate effective October 1, 2006. For the fiscal years ending June 30, 2010, and June 30, 2011, rates in effect for the period ending June 30, 2009, shall remain in effect until June 30, 2011, except any facility that would have been issued a lower rate for the fiscal year ending June 30, 2010, or the fiscal year ending June 30, 2011, due to interim rate status or agreement with the department, shall be issued such lower rate, except (i) any facility that would have been issued a lower rate for the fiscal year ending June 30, 2010, or the fiscal year ending June 30, 2011, due to interim rate status

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or agreement with the Commissioner of Social Services shall be issued such lower rate; and (ii) the commissioner may increase a facility's rate for reasonable costs associated with such facility's compliance with the provisions of section 19a-495a concerning the administration of medication by unlicensed personnel. For the fiscal year ending June 30, 2012, rates in effect for the period ending June 30, 2011, shall remain in effect until June 30, 2012, except that (I) any facility that would have been issued a lower rate for the fiscal year ending June 30, 2012, due to interim rate status or agreement with the Commissioner of Social Services shall be issued such lower rate; and (II) the commissioner may increase a facility's rate for reasonable costs associated with such facility's compliance with the provisions of section 19a-495a concerning the administration of medication by unlicensed personnel. For the fiscal year ending June 30, 2013, the Commissioner of Social Services may, within available appropriations, provide a rate increase to a residential care home. Any facility that would have been issued a lower rate for the fiscal year ending June 30, 2013, due to interim rate status or agreement with the Commissioner of Social Services shall be issued such lower rate. For the fiscal years ending June 30, 2012, and June 30, 2013, the Commissioner of Social Services may provide fair rent increases to any facility that has undergone a material change in circumstances related to fair rent and has an approved certificate of need pursuant to section 17b-352, as amended by this act, 17b-353, 17b-354 or 17b-355.

(2) The commissioner shall, upon determining that a loan to be issued to a residential care home by the Connecticut Housing Finance Authority is reasonable in relation to the useful life and property cost allowance pursuant to section 17-311-52 of the regulations of Connecticut state agencies, allow actual debt service, comprised of principal, interest and a repair and replacement reserve on the loan, in lieu of allowed property costs whether actual debt service is higher or lower than such allowed property costs.

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(i) Notwithstanding the provisions of this section, the Commissioner of Social Services shall establish a fee schedule for payments to be made to chronic disease hospitals associated with chronic and convalescent nursing homes to be effective on and after July 1, 1995. The fee schedule may be adjusted annually beginning July 1, 1997, to reflect necessary increases in the cost of services.

Sec. 10. Section 17b-340a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2013*):

(a) For purposes of this section and section 17b-340b, as amended by this act:

(1) "Commissioner" means the Commissioner of Revenue Services;

(2) "Department" means the Department of Revenue Services;

(3) "Intermediate care facility for [the mentally retarded] individuals with intellectual disabilities" or "intermediate care facility" means a residential facility for [the mentally retarded] persons with intellectual disability which is certified to meet the requirements of 42 CFR 442, Subpart C and, in the case of a private facility, licensed pursuant to section 17a-227;

(4) "Resident day" means a day of intermediate care facility residential care provided to an individual and includes the day a resident is admitted and any day for which the intermediate care facility is eligible for payment for reserving a resident's bed due to hospitalization or temporary leave and for the date of death. For purposes of this subdivision, a day of care shall be the period of time between the census-taking hour in a facility on two successive calendar days. "Resident day" does not include the day a resident is discharged;

(5) "Intermediate care facility for [the mentally retarded] individuals with intellectual disabilities net revenue" means amounts billed by an

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intermediate care facility for all services provided, including room, board and ancillary services, minus (A) contractual allowances, (B) payer discounts, (C) charity care, and (D) bad debts; and

(6) "Contractual allowances" means the amount of discounts allowed by an intermediate care facility to certain payers from amounts billed for room, board and ancillary services.

(b) (1) For each calendar quarter commencing on or after July 1, 2011, there is hereby imposed a resident day user fee on each intermediate care facility for [the mentally retarded] individuals with intellectual disabilities in this state, which fee shall be the product of the facility's total resident days during the calendar quarter multiplied by the user fee, as determined by the Commissioner of Social Services pursuant to section 17b-340b, as amended by this act.

(2) Each intermediate care facility for [the mentally retarded] individuals with intellectual disabilities shall, on or before the last day of January, April, July and October of each year, render to the commissioner a return, on forms prescribed or furnished by the commissioner, stating the intermediate care facility's total resident days during the calendar quarter ending on the last day of the preceding month and stating such other information as the commissioner deems necessary for the proper administration of the provisions of this section. The resident day user fee imposed under this section shall be due and payable on the due date of such return. Each intermediate care facility shall be required to file such return electronically with the department and to make such payment by electronic funds transfer in the manner provided by chapter 228g, irrespective of whether such facility would have otherwise been required to file such return electronically or to make such payment by electronic funds transfer under the provisions of chapter 228g.

(c) Whenever such resident day user fee is not paid when due, a

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penalty of ten per cent of the amount due or fifty dollars, whichever is greater, shall be imposed, and interest at the rate of one per cent per month or a fraction thereof shall accrue on such user fee from the due date of such user fee until the date of payment.

(d) The commissioner shall notify the Commissioner of Social Services of any amount delinquent under section 17b-340b, as amended by this act, and, upon receipt of such notice, the Commissioner of Social Services shall deduct and withhold such amount from amounts otherwise payable by the Department of Social Services to the delinquent facility.

(e) The provisions of section 12-548, sections 12-550 to 12-554, inclusive, and section 12-555a shall apply to the provisions of this section in the same manner and with the same force and effect as if the language of said sections had been incorporated in full into this section and had expressly referred to the user fee imposed under this section, except to the extent that any provision is inconsistent with a provision in this section. For purposes of section 12-39g, the resident day user fee shall be treated as a tax.

(f) The commissioner may enter into an agreement with the Commissioner of Social Services delegating to the Commissioner of Social Services the authority to examine the records and returns of any intermediate care facility for [the mentally retarded] individuals with intellectual disabilities in this state subject to the resident day user fee imposed under this section and to determine whether such user fee has been underpaid or overpaid. If such authority is so delegated, examinations of such records and returns by the Commissioner of Social Services and determinations by the Commissioner of Social Services that such user fee has been underpaid or overpaid shall have the same effect as similar examinations or determinations made by the Commissioner of Revenue Services.

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(g) (1) The commissioner shall not collect the resident day user fee pursuant to this section until the Commissioner of Social Services informs the commissioner that all the necessary federal approvals are in effect to secure federal financial participation matching funds associated with any authorized facility rate increases.

(2) The commissioner shall cease to collect the resident day user fee pursuant to this section if the Commissioner of Social Services informs the commissioner that the federal approvals described in subdivision (1) of this subsection are withheld or withdrawn.

Sec. 11. Section 17b-340b of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2013*):

On or before July 1, 2011, and on or before July first annually or biennially thereafter, the Commissioner of Social Services shall determine the amount of the user fee and promptly notify the commissioner and the intermediate care facilities for [the mentally retarded] individuals with intellectual disabilities of such amount. The user fee shall be (1) the sum of each facility's anticipated net revenue, including, but not limited to, its estimated net revenue from any increases in Medicaid payments during the twelve-month period ending on June thirtieth of the succeeding calendar year, (2) which sum shall be multiplied by a percentage as determined by the Secretary of the Office of Policy and Management, in consultation with the Commissioner of Social Services, provided, before October 1, 2011, such percentage shall not exceed five and one-half per cent and, on and after October 1, 2011, such percentage shall not exceed the maximum amount allowed under federal law, and (3) which product shall be divided by the sum of each facility's anticipated resident days during the twelve-month period ending on June thirtieth of the succeeding calendar year. The Commissioner of Social Services, in anticipating facility net revenue and resident days, shall use the most recently available facility net revenue and resident day information.

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Notwithstanding the provisions of this section, the Commissioner of Social Services may adjust the user fee as necessary to prevent the state from exceeding the maximum amount allowed under federal law.

Sec. 12. Section 17b-352 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2013*):

(a) For the purposes of this section and section 17b-353, "facility" means a residential facility for [the mentally retarded] persons with intellectual disability licensed pursuant to section 17a-277 and certified to participate in the Title XIX Medicaid program as an intermediate care facility for [the mentally retarded] individuals with intellectual disabilities, a nursing home, rest home or residential care home, as defined in section 19a-490, as amended by this act.

(b) Any facility which intends to (1) transfer all or part of its ownership or control prior to being initially licensed; (2) introduce any additional function or service into its program of care or expand an existing function or service; or (3) terminate a service or decrease substantially its total bed capacity, shall submit a complete request for permission to implement such transfer, addition, expansion, increase, termination or decrease with such information as the department requires to the Department of Social Services, provided no permission or request for permission to close a facility is required when a facility in receivership is closed by order of the Superior Court pursuant to section 19a-545. The Office of the Long-Term Care Ombudsman pursuant to section 17b-400 shall be notified by the facility of any proposed actions pursuant to this subsection at the same time the request for permission is submitted to the department and when a facility in receivership is closed by order of the Superior Court pursuant to section 19a-545.

(c) An applicant, prior to submitting a certificate of need application, shall request, in writing, application forms and

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instructions from the department. The request shall include: (1) The name of the applicant or applicants; (2) a statement indicating whether the application is for (A) a new, additional, expanded or replacement facility, service or function, (B) a termination or reduction in a presently authorized service or bed capacity or (C) any new, additional or terminated beds and their type; (3) the estimated capital cost; (4) the town where the project is or will be located; and (5) a brief description of the proposed project. Such request shall be deemed a letter of intent. No certificate of need application shall be considered submitted to the department unless a current letter of intent, specific to the proposal and in accordance with the provisions of this subsection, has been on file with the department for not less than ten business days. For purposes of this subsection, "a current letter of intent" means a letter of intent on file with the department for not more than one hundred eighty days. A certificate of need application shall be deemed withdrawn by the department, if a department completeness letter is not responded to within one hundred eighty days. The Office of the Long-Term Care Ombudsman shall be notified by the facility at the same time as the letter of intent is submitted to the department.

(d) Any facility acting pursuant to subdivision (3) of subsection (b) of this section shall provide written notice, at the same time it submits its letter of intent, to all patients, guardians or conservators, if any, or legally liable relatives or other responsible parties, if known, and shall post such notice in a conspicuous location at the facility. The notice shall state the following: (A) The projected date the facility will be submitting its certificate of need application, (B) that only the department has the authority to either grant, modify or deny the application, (C) that the department has up to ninety days to grant, modify or deny the certificate of need application, (D) a brief description of the reason or reasons for submitting a request for permission, (E) that no patient shall be involuntarily transferred or discharged within or from a facility pursuant to state and federal law

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because of the filing of the certificate of need application, (F) that all patients have a right to appeal any proposed transfer or discharge, and (G) the name, mailing address and telephone number of the Office of the Long-Term Care Ombudsman and local legal aid office.

(e) The department shall review a request made pursuant to subsection (b) of this section to the extent it deems necessary, including, but not limited to, in the case of a proposed transfer of ownership or control prior to initial licensure, the financial responsibility and business interests of the transferee and the ability of the facility to continue to provide needed services, or in the case of the addition or expansion of a function or service, ascertaining the availability of the function or service at other facilities within the area to be served, the need for the service or function within the area and any other factors the department deems relevant to a determination of whether the facility is justified in adding or expanding the function or service. The commissioner shall grant, modify or deny the request within ninety days of receipt thereof, except as otherwise provided in this section. Upon the request of the applicant, the review period may be extended for an additional fifteen days if the department has requested additional information subsequent to the commencement of the commissioner's review period. The director of the office of certificate of need and rate setting may extend the review period for a maximum of thirty days if the applicant has not filed in a timely manner information deemed necessary by the department. The applicant may request and shall receive a hearing in accordance with section 4-177 if aggrieved by a decision of the commissioner.

(f) The Commissioner of Social Services shall not approve any requests for beds in residential facilities for [the mentally retarded] persons with intellectual disability which are licensed pursuant to section 17a-227 and are certified to participate in the Title XIX Medicaid Program as intermediate care facilities for [the mentally

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retarded] individuals with intellectual disabilities, except those beds necessary to implement the residential placement goals of the Department of Developmental Services which are within available appropriations.

(g) The Commissioner of Social Services shall adopt regulations, in accordance with chapter 54, to implement the provisions of this section. The commissioner shall implement the standards and procedures of the Office of Health Care Access division of the Department of Public Health concerning certificates of need established pursuant to section 19a-643, as appropriate for the purposes of this section, until the time final regulations are adopted in accordance with said chapter 54.

Sec. 13. Section 17b-356 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2013*):

Any health care facility or institution, as defined in subsection (a) of section 19a-490, as amended by this act, except a nursing home, rest home, residential care home or residential facility for [the mentally retarded] persons with intellectual disability licensed pursuant to section 17a-227 and certified to participate in the Title XIX Medicaid program as an intermediate care facility for [the mentally retarded] individuals with intellectual disabilities, proposing to expand its services by adding nursing home beds shall obtain the approval of the Commissioner of Social Services in accordance with the procedures established pursuant to sections 17b-352, as amended by this act, 17b-353 and 17b-354 for a facility, as defined in section 17b-352, as amended by this act, prior to obtaining the approval of the Office of Health Care Access division of the Department of Public Health pursuant to section 19a-639.

Sec. 14. Section 17b-363b of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2013*):

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(a) The Commissioner of Social Services may, within available appropriations, provide reimbursement to pharmacies or pharmacists for services provided to residents in long-term care facilities, including (1) residential care homes, nursing homes or rest homes, as defined in section 19a-490, as amended by this act, (2) residential facilities for ~~[mentally retarded persons]~~ persons with intellectual disability, as defined in section 17a-231, or (3) facilities served by assisted living services agencies, as defined in section 19a-490, as amended by this act, in addition to those reimbursements provided in chapter 319v, provided such services improve the quality of care to residents of such facilities and produce cost savings to the state, as determined by the commissioner. Such services may include, but not be limited to, emergency and delivery services provided such services are offered on all medications, including intravenous therapy, twenty-four hours per day and seven days per week.

(b) The Commissioner of Social Services may reimburse for prescription drug costs in unit dose packaging, including blister packs and other special packaging, for clients residing in nursing facilities, chronic disease hospitals and intermediate care facilities for ~~[the mentally retarded]~~ individuals with intellectual disabilities.

Sec. 15. Subsection (a) of section 19a-490 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2013*):

(a) "Institution" means a hospital, residential care home, health care facility for the handicapped, nursing home, rest home, home health care agency, homemaker-home health aide agency, mental health facility, assisted living services agency, substance abuse treatment facility, outpatient surgical facility, an infirmary operated by an educational institution for the care of students enrolled in, and faculty and employees of, such institution; a facility engaged in providing services for the prevention, diagnosis, treatment or care of human

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health conditions, including facilities operated and maintained by any state agency, except facilities for the care or treatment of mentally ill persons or persons with substance abuse problems; and a residential facility for [the mentally retarded] persons with intellectual disability licensed pursuant to section 17a-227 and certified to participate in the Title XIX Medicaid program as an intermediate care facility for [the mentally retarded] individuals with intellectual disabilities;

Sec. 16. Subdivision (4) of subsection (a) of section 19a-491c of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2013*):

(4) "Long-term care facility" means any facility, agency or provider that is a nursing home, as defined in section 19a-521, a home health agency, as defined in section 19a-490, as amended by this act, an assisted living services agency, as defined in section 19a-490, as amended by this act, an intermediate care facility for [the mentally retarded] individuals with intellectual disabilities, as defined in 42 USC 1396d(d), a chronic disease hospital, as defined in section 19a-550, or an agency providing hospice care which is licensed to provide such care by the Department of Public Health or certified to provide such care pursuant to 42 USC 1395x.

Sec. 17. Subdivision (17) of subsection (b) of section 19a-638 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2013*):

(17) A residential facility for persons with intellectual disability licensed pursuant to section 17a-227 and certified to participate in the Title XIX Medicaid program as an intermediate care facility for [the mentally retarded] individuals with intellectual disabilities;

Sec. 18. Section 14-96p of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2013*):

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(a) (1) No person shall display upon any motor vehicle any light visible from the front thereof other than white, yellow or amber, or any light other than red, yellow, amber or white visible from the rear thereof, except a light used with any school bus, without a special permit from the commissioner, in accordance with the provisions of subsection (c) of section 14-96q, as amended by this act. Notwithstanding this subsection, no permit shall be required for motor vehicles that are (A) equipped with lights in accordance with this section and section 14-96q, as amended by this act, (B) owned or leased by the federal government, the state of Connecticut or a Connecticut municipality, (C) registered to such governmental entity, and (D) displaying government plates.

(2) Any vehicle accommodating fifteen or fewer [handicapped] students with disabilities may use a flashing red light or lights during the time such vehicle is stopped for the purpose of receiving or discharging such [handicapped] students with disabilities, any motor bus may carry a purple light or lights, any interstate public service vehicle may carry a green light or lights, any taxicab may carry a lunar white light or lights, and any interstate commercial motor vehicle may display green identification lights, in front thereof, as the commissioner may permit.

(3) A vehicle being operated by the chief executive officer of an emergency medical service organization, as defined in section 19a-175, the first or second deputies, or if there are no deputies, the first or second assistants, of such an organization that is a municipal or volunteer or licensed organization, an ambulance, as defined in section 19a-175, a vehicle being operated by a local fire marshal or a local director of emergency management may use a flashing red light or lights or flashing white head lamps and a flashing amber light while on the way to the scene of an emergency, except that an ambulance may use flashing lights of other colors specified by federal

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requirements for the manufacture of such vehicle. The chief executive officer of each such organization shall provide annually during the month of January, on forms provided by the commissioner, such officer's name and address and the registration number on the number plate or plates of the vehicle on which the authorized red light is or white head lamps and amber light are to be used. A vehicle being operated by a member of a volunteer fire department or company or a volunteer emergency medical technician may use flashing white head lamps, provided such member or emergency medical technician is on the way to the scene of a fire or medical emergency and has received written authorization from the chief law enforcement officer of the municipality to use such head lamps. Such head lamps shall only be used within the municipality granting such authorization or from a personal residence or place of employment, if located in an adjoining municipality. Such authorization may be revoked for use of such head lamps in violation of this subdivision.

(4) Flashing or revolving white lights may not be displayed upon a motor vehicle except (A) on fire emergency apparatus, (B) on motor vehicles of paid fire chiefs and their deputies and assistants, up to a total of five individuals per department, and may be displayed in combination with flashing or revolving red lights, (C) on motor vehicles of volunteer fire chiefs and their deputies and assistants, up to a total of five individuals per department, and may be displayed in combination with flashing or revolving red lights, (D) as a means of indicating a right or left turn, (E) in conjunction with flashing red lights on an ambulance responding to an emergency call, or (F) on the top rear of any school bus. For the purpose of this subsection, the term ["handicapped students" means mentally retarded, hard of hearing, deaf, speech-impaired, visually handicapped, emotionally disturbed, orthopedically impaired or other health-impaired students, or students with specific learning disabilities] "students with disabilities" means students who have intellectual disability, autism spectrum disorder,

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mental disability, visual impairment, blindness, hearing impairment, deafness, speech impairment, orthopedic impairment, or another health-impairment, who by reason thereof, require special education and related services; and the term "flashing white lights" shall not include the simultaneous flashing of head lamps.

(b) A blue light may not be illuminated upon a motor vehicle, except that a vehicle being operated by an active member of a volunteer fire department or company or an active member of an organized civil preparedness auxiliary fire company who has been authorized in writing by the chief executive officer of such department or company may use such a light, including a flashing blue light, while on the way to the scene of a fire or other emergency requiring his or her services. Such authorization may be revoked by such officer or his or her successor. The chief executive officer of each volunteer fire department or company or organized civil preparedness auxiliary fire company shall certify annually during the month of January, on forms provided by the commissioner, the names and addresses of members whom he or she has authorized to use a blue light as provided in this subsection. Such listing shall also designate the registration number on the number plate or plates of the vehicle on which the authorized blue light is to be used.

(c) A flashing green light may not be used upon a motor vehicle, except that a vehicle being operated by an active member of a volunteer ambulance association or company who has been authorized in writing by the chief executive officer of such association or company may use such a light while on the way to the scene of an emergency requiring his or her services. Such authorization may be revoked by such officer or his or her successor. The chief executive officer of each volunteer ambulance association or company shall certify annually during the month of January, on forms provided by the commissioner, the names and addresses of members whom he or she has authorized

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to use a green light as provided in this subsection. Such listing shall also designate the registration number on the number plate or plates of the vehicle on which the authorized green light is to be used.

(d) Use of lights except as authorized by this section shall be an infraction.

Sec. 19. Section 17a-75 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2013*):

For the purposes of sections 17a-75 to 17a-83, inclusive, as amended by this act, the following terms shall have the following meanings: "Business day" means Monday through Friday except when a legal holiday falls thereon; "child" means any person less than sixteen years of age; "court" means the Superior Court-Juvenile Matters or the Court of Probate, unless either court is specifically stated; "hospital for mental illness of children" means any hospital, [which] that provides, in whole or in part, diagnostic or treatment services for mental disorders of children, but shall not include any correctional institution of this state; "mental disorder" means a mental or emotional condition [which] that has substantial adverse effects on a child's ability to function so as to jeopardize his or her health, safety or welfare or that of others, and specifically excludes [mental retardation] intellectual disability; "parent" means parent or legal guardian, including any guardian appointed under the provisions of subsection (i) of section 46b-129 or sections 45a-132, 45a-593 to 45a-597, inclusive, 45a-603 to 45a-622, inclusive, 45a-629 to 45a-638, inclusive, 45a-707 to 45a-709, inclusive, 45a-715 to 45a-718, inclusive, 45a-724 to 45a-737, inclusive, or 45a-743 to 45a-756, inclusive.

Sec. 20. Section 17a-451d of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2013*):

There is established a nonlapsing fund that shall contain (1) any

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moneys received by the state from the sale, lease or transfer of all or any part of Norwich Hospital or any regional center that takes place after January 1, 2001, and (2) any other moneys required by law to be deposited in a separate account within the General Fund for purposes of this section, section 17a-212a or section 4 of public act 01-154. The Treasurer shall credit the fund with its investment earnings. Any balance remaining in said fund at the end of any fiscal year shall be carried forward in the fund for the fiscal year next succeeding. The principal and interest of the fund shall be used solely for the purpose of site acquisition, capital development and infrastructure costs necessary to provide services to persons with [mental retardation] intellectual disability or psychiatric disabilities, provided amounts in the fund may be expended only pursuant to appropriation by the General Assembly.

Sec. 21. Section 17b-28a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2013*):

(a) There is established a Waiver Application Development Council that shall be composed of the following members: The chairpersons and ranking members of the joint standing committee of the General Assembly having cognizance of matters relating to appropriations, or their designees; the chairpersons and ranking members of the joint standing committee of the General Assembly having cognizance of matters relating to human services, or their designees; the chairpersons and ranking members of the joint standing committee of the General Assembly having cognizance of matters relating to public health, or their designees; the Commissioner of Social Services, or [his] the commissioner's designee; the Commissioner of Public Health, or [his] the commissioner's designee; the Commissioner of Mental Health and Addiction Services, or [his] the commissioner's designee; the Commissioner of Developmental Services, or [his] the commissioner's designee; the Secretary of the Office of Policy and Management, or

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[his] the secretary's designee; the State Comptroller, or [his] the comptroller's designee; a representative of advocacy for [mental retardation] persons with intellectual disability to be appointed by the president pro tempore of the Senate; a representative of advocacy for the elderly to be appointed by the majority leader of the Senate; a representative of the nursing home industry to be appointed by the minority leader of the Senate; a representative of the home health care industry, independent of the nursing home industry, to be appointed by the speaker of the House of Representatives; a representative of the mental health profession to be appointed by the majority leader of the House of Representatives; a representative of the substance abuse profession to be appointed by the minority leader of the House of Representatives; a health care provider to be appointed by the president pro tempore of the Senate; two elderly consumers of Medicaid services who are also eligible for Medicare, to be appointed by the speaker of the House of Representatives; a representative of the managed care industry, to be appointed by the president pro tempore of the Senate; a social services care provider, to be appointed by the majority leader of the House of Representatives; a family support care provider, to be appointed by the majority leader of the Senate; two persons with disabilities who are consumers of Medicaid services, one to be appointed by the president pro tempore of the Senate and one to be appointed by the minority leader of the House of Representatives; a representative of legal advocacy for Medicaid clients, to be appointed by the minority leader of the Senate; and six members of the General Assembly, one member appointed by the president pro tempore of the Senate; one member appointed by the majority leader of the Senate; one member appointed by the minority leader of the Senate; one member appointed by the speaker of the House of Representatives; one member appointed by the majority leader of the House of Representatives; and one member appointed by the minority leader of the House of Representatives. The council shall be responsible for advising the Department of Social Services, which shall be the lead

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agency in the development of a Medicaid Research and Demonstration Waiver under Section 1115 of the Social Security Act for application to the Office of State Health Reform of the United States Department of Health and Human Services by May 1, 1996. The council shall advise the department with respect to specific provisions within the waiver application, including but not limited to, the identification of populations to be included in a managed care program, a timetable for inclusion of distinct populations, expansion of access to care, quality assurance and grievance procedures for consumers and providers. The council shall also advise the department with respect to the goals of the waiver, including but not limited to, the expansion of access and coverage, making state health spending more efficient and to the reduction of uncompensated care.

(b) There is established a Medicaid waiver unit within the Department of Social Services for the purposes of developing the waiver under subsection (a) of this section. The Medicaid waiver unit's responsibilities shall include but not be limited to the following: (1) Administering the Medicaid managed care program, established pursuant to section 17b-28; (2) contracting with and evaluating prepaid health plans providing Medicaid services, including negotiation and establishment of capitated rates; (3) assessing quality assurance information compiled by the federally required independent quality assurance contractor; (4) monitoring contractual compliance; (5) evaluating enrollment broker performance; (6) providing assistance to the Insurance Department for the regulation of Medicaid managed care health plans; and (7) developing a system to compare performance levels among prepaid health plans providing Medicaid services.

Sec. 22. Section 17b-112c of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2013*):

(a) Qualified aliens, as defined in Section 431 of Public Law 104-193,

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who do not qualify for federally-funded cash assistance, other lawfully residing immigrant aliens or aliens who formerly held the status of permanently residing under color of law shall be eligible for solely state-funded temporary family assistance or cash assistance under the state-administered general assistance program, provided other conditions of eligibility are met. An individual who is granted assistance under this section must pursue citizenship to the maximum extent allowed by law as a condition of eligibility unless incapable of doing so due to a medical problem, language barrier or other reason as determined by the Commissioner of Social Services. Notwithstanding the provisions of this section, any qualified alien or other lawfully residing immigrant alien or alien who formerly held the status of permanently residing under color of law who is a victim of domestic violence or who has [mental retardation] intellectual disability shall be eligible for assistance under this section.

(b) Notwithstanding the provisions of subsection (a) of this section: (1) A qualified alien admitted into the United States on or after August 22, 1996, or other lawfully residing immigrant alien determined eligible for temporary family assistance or cash assistance under the state-administered general assistance program prior to July 1, 1997, or other lawfully residing immigrant alien or alien who formerly held the status of permanently residing under color of law, shall remain eligible, and (2) a qualified alien, other lawfully residing immigrant alien admitted into the United States on or after August 22, 1996, other lawfully residing immigrant alien or an alien who formerly held the status of permanently residing under color of law and not determined eligible prior to July 1, 1997, shall be eligible for such assistance subsequent to six months from establishing residency in this state.

(c) Notwithstanding the provisions of this section, a qualified alien or other lawfully residing immigrant alien or alien who formerly held the status of permanently residing under color of law who is a victim

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of domestic violence or who has [mental retardation] intellectual disability shall be eligible for assistance under this section.

Sec. 23. Section 17b-260b of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2013*):

The Commissioner of Social Services may amend the federal home and community-based service waivers serving persons with acquired brain injury and persons with [mental retardation] intellectual disability to enable such persons eligible for or receiving medical assistance under section 17b-597 to receive the services provided under such federally-approved waivers.

Sec. 24. Subsection (a) of section 17b-342 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2013*):

(a) The Commissioner of Social Services shall administer the Connecticut home-care program for the elderly state-wide in order to prevent the institutionalization of elderly persons (1) who are recipients of medical assistance, (2) who are eligible for such assistance, (3) who would be eligible for medical assistance if residing in a nursing facility, or (4) who meet the criteria for the state-funded portion of the program under subsection (i) of this section. For purposes of this section, a long-term care facility is a facility [which] that has been federally certified as a skilled nursing facility or intermediate care facility. The commissioner shall make any revisions in the state Medicaid plan required by Title XIX of the Social Security Act prior to implementing the program. The annualized cost of the community-based services provided to such persons under the program shall not exceed sixty per cent of the weighted average cost of care in skilled nursing facilities and intermediate care facilities. The program shall be structured so that the net cost to the state for long-term facility care in combination with the community-based services

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under the program shall not exceed the net cost the state would have incurred without the program. The commissioner shall investigate the possibility of receiving federal funds for the program and shall apply for any necessary federal waivers. A recipient of services under the program, and the estate and legally liable relatives of the recipient, shall be responsible for reimbursement to the state for such services to the same extent required of a recipient of assistance under the state supplement program, medical assistance program, temporary family assistance program or supplemental nutrition assistance program. Only a United States citizen or a noncitizen who meets the citizenship requirements for eligibility under the Medicaid program shall be eligible for home-care services under this section, except a qualified alien, as defined in Section 431 of Public Law 104-193, admitted into the United States on or after August 22, 1996, or other lawfully residing immigrant alien determined eligible for services under this section prior to July 1, 1997, shall remain eligible for such services. Qualified aliens or other lawfully residing immigrant aliens not determined eligible prior to July 1, 1997, shall be eligible for services under this section subsequent to six months from establishing residency. Notwithstanding the provisions of this subsection, any qualified alien or other lawfully residing immigrant alien or alien who formerly held the status of permanently residing under color of law who is a victim of domestic violence or who has [mental retardation] intellectual disability shall be eligible for assistance pursuant to this section. Qualified aliens, as defined in Section 431 of Public Law 104-193, or other lawfully residing immigrant aliens or aliens who formerly held the status of permanently residing under color of law shall be eligible for services under this section provided other conditions of eligibility are met.

Sec. 25. Section 17b-360 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2013*):

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(a) For purposes of this section, the terms ["mental retardation"] "intellectual disability", "a condition related to [mental retardation] intellectual disability" and "specialized services" shall be as defined in Subsection (e)(7)(G)(ii) of Section 1919 of the Social Security Act and federal regulations.

(b) No nursing facility may admit any new resident irrespective of source of payment, who has [mental retardation] intellectual disability or has a condition related to [mental retardation] intellectual disability unless the Department of Developmental Services has determined prior to admission based upon an independent physical and mental evaluation performed by or under the auspices of the Department of Social Services that because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility. If the individual requires such level of services, the Department of Developmental Services shall also determine whether the individual requires specialized services for such condition. An individual who is determined by the Department of Developmental Services to have [mental retardation] intellectual disability or to have a related condition and is determined not to require nursing facility level of services shall not be admitted to a nursing facility. In order to implement the preadmission review requirements of this section, and to identify applicants for admission who may have [mental retardation] intellectual disability or have conditions related to [mental retardation] intellectual disability and subject to the requirements of this section, nursing facilities may not admit any individual irrespective of source of payment, unless an identification screen developed, or in the case of out-of-state residents approved, by the Department of Social Services has been completed for the applicant and filed in accordance with federal law.

(c) No payment from any source shall be due to a nursing facility that admits a resident in violation of the preadmission screening

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requirements of this section.

(d) A nursing facility shall notify the Department of Developmental Services when a resident who has [mental retardation] intellectual disability undergoes a change in condition or when a resident who has not previously been diagnosed as having [mental retardation] intellectual disability undergoes a significant change in condition [which] that may require specialized services. Upon such notification, the Department of Developmental Services, under the auspices of the Department of Social Services, shall perform an evaluation to determine whether the resident requires the level of services provided by a nursing facility or requires specialized services for [mental retardation] intellectual disability.

(e) In the case of a resident who is determined under subsection (d) of this section not to require the level of services provided by a nursing facility but to require specialized services for [mental retardation] intellectual disability or a condition related to [mental retardation] intellectual disability and who has continually resided in a nursing facility for at least thirty months before the date of the determination, the resident may elect to remain in the facility or to receive services covered by Medicaid in an alternative appropriate institutional or noninstitutional setting in accordance with the terms of the alternative disposition plan submitted by the Department of Social Services and approved by the Secretary of the United States Department of Health and Human Services.

(f) In the case of a resident with [mental retardation] intellectual disability or a related condition who is determined under subsection (d) of this section not to require the level of services provided by a nursing facility but to require specialized services for [mental retardation] intellectual disability or a related condition and who has not continuously resided in a nursing facility for at least thirty months before the date of the determination, the nursing facility, in

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consultation with the Department of Developmental Services, shall arrange for the safe and orderly discharge of the resident from the facility. If the department determines that the provision of specialized services requires an alternative residential placement, the discharge and transfer of the patient shall be in accordance with the alternative disposition plan submitted by the Department of Social Services and approved by the Secretary of the United States Department of Health and Human Services, except if an alternative residential facility is not available, the resident shall not be transferred.

(g) In the case of a resident who is determined under subsection (d) of this section not to require the level of services provided by a nursing facility and not to require specialized services, the nursing facility shall arrange for the safe and orderly discharge of the resident from the facility.

(h) The Department of Developmental Services shall be the agency responsible for making the determinations required by this section on behalf of individuals who have [mental retardation] intellectual disability and on behalf of individuals with conditions related to [mental retardation] intellectual disability and may provide services to such individuals to the extent required by federal law.

(i) Any person seeking admittance to a nursing facility or any resident of a nursing facility who is adversely affected by a determination of the Department of Developmental Services under this section may appeal such determination to the Department of Social Services within fifteen days of the receipt of the notice of a determination by the Department of Developmental Services. If an appeal is taken to the Department of Social Services, the determination of the Department of Developmental Services shall be stayed pending determination by the Department of Social Services.

Sec. 26. Subsection (a) of section 17b-616 of the general statutes is

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repealed and the following is substituted in lieu thereof (*Effective October 1, 2013*):

(a) As used in this section:

(1) "Child with a disability" means any child who is developmentally disabled as defined in 42 USC 6001(7), except a child with [mental retardation] intellectual disability.

(2) "Family applicant" means any parent or other family member who resides in the same household as a child with a disability and who has primary responsibility for providing continuous care to the child.

(3) "Family support" means the monthly payment given to a family applicant pursuant to this section and the regulations adopted by the Commissioner of Social Services for the family support grant program.

Sec. 27. Subsection (e) of section 19a-6h of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2013*):

(e) The State-wide Primary Care Access Authority shall:

(1) Determine what constitutes primary care services for purposes of subdivisions (2) to (4), inclusive, of this section;

(2) Inventory the state's existing primary care infrastructure, including, but not limited to, (A) the number of primary care providers practicing in the state, (B) the total amount of money expended on public and private primary care services during the last fiscal year, (C) the number of public and private buildings or offices used primarily for the rendering of primary care services, including, but not limited to, hospitals, mental health facilities, dental offices, school-based health clinics, community-based health centers and academic health centers. For the purposes of this subdivision, "primary care provider" means

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any physician, dentist, nurse, provider of services for [the mentally ill or persons with mental retardation] persons with psychiatric disabilities or persons with intellectual disability, or other person involved in providing primary medical, nursing, counseling, or other health care, substance abuse or mental health service, including such services associated with, or under contract to, a health maintenance organization or medical services plan.

(3) Not later than December 31, 2008, develop a universal system for providing primary care services, including prescription drugs, to all residents of the state that maximizes federal financial participation in Medicaid and Medicare. The committee shall (A) estimate the cost of fully implementing such universal system, (B) identify any additional infrastructure or personnel that would be necessary in order to fully implement such universal system, (C) determine the state's role and the role of third party entities in administering such universal system, (D) identify funding sources for such universal system, and (E) determine the role of private health insurance in such universal system.

(4) Develop a plan for implementing by July 1, 2010, the universal primary care system developed pursuant to subdivision (3) of this section. Such plan shall (A) include a timetable for implementation of the universal primary care system, (B) establish benchmarks to assess the state's progress in implementing the system, and (C) establish mechanisms for assessing the effectiveness of the primary care system, once implemented.

Sec. 28. Subdivisions (11) and (12) of section 19a-581 of the general statutes are repealed and the following is substituted in lieu thereof (*Effective October 1, 2013*):

(11) "Health facility" means an institution, as defined in section 19a-490, as amended by this act, blood bank, blood center, sperm bank,

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organ or tissue bank, clinical laboratory or facility providing care or treatment to [the mentally ill or persons with mental retardation] persons with psychiatric disabilities or persons with intellectual disability or a facility for the treatment of substance abuse;

(12) "Health care provider" means any physician, dentist, nurse, provider of services for [the mentally ill or persons with mental retardation,] persons with psychiatric disabilities or persons with intellectual disability or other person involved in providing medical, nursing, counseling, or other health care, substance abuse or mental health service, including such services associated with, or under contract to, a health maintenance organization or medical services plan;

Sec. 29. Section 26-29a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2013*):

No fee shall be charged for any sport fishing license issued under this chapter to any person with [mental retardation] intellectual disability, and such license shall be a lifetime license not subject to the expiration provisions of section 26-35. Proof of [mental retardation] intellectual disability shall consist of a certificate to that effect issued by any person licensed to practice medicine and surgery in this state.

Sec. 30. Subsection (b) of section 27-103 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2013*):

(b) As used in this part, "home" means the Veterans' Home maintained by the state; "hospital" means any incorporated hospital or tuberculosis sanatorium in the state and any state chronic disease hospital, [mental hospital or training school for the mentally retarded] or hospital for persons with mental illness, "veteran" means any veteran who served in time of war, as defined in subsection (a) of this

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section, and who is a resident of this state, provided, if he or she was not a resident or resident alien of this state at the time of enlistment or induction into the armed forces, he or she shall have resided continuously in this state for at least two years; "eligible dependent" means any parent, wife or husband, or child of a veteran who has no adequate means of support; and "eligible family member" means any parent, brother or sister, wife or husband, or child or children under eighteen years of age, of any veteran whose cooperation in the program is integral to the treatment of the veteran.

Sec. 31. Subsection (e) of section 31-57e of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2013*):

(e) The Employment Rights Code referred to under this section shall include the following provisions:

(1) A commercial enterprise subject to tribal jurisdiction shall not, except in the case of a bona fide occupational qualification or need, refuse to hire or employ or bar or discharge from employment any individual or discriminate against him or her in compensation or in terms, conditions or privileges of employment because of the individual's race, color, religious creed, sex, gender identity or expression, marital status, national origin, ancestry, age, present or past history of mental disorder, [mental retardation] intellectual disability, sexual orientation, learning or physical disability, political activity, union activity or the exercise of rights protected by the United States Constitution. This subdivision shall not be construed to restrict the right of a tribe to give preference in hiring to members of the tribe.

(2) A commercial enterprise subject to tribal jurisdiction shall not deny any individual, including a representative of a labor organization, seeking to ensure compliance with this section, access to employees of the tribe's commercial enterprise during nonwork time in

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nonwork areas. The tribe shall not permit any supervisor, manager or other agent of the tribe to restrict or otherwise interfere with such access.

(3) When a labor organization claims that it has been designated or selected for the purposes of collective bargaining by the majority of the employees in a unit appropriate for such purposes, the labor organization may apply to an arbitrator to verify the claim pursuant to subdivision (4) of this subsection. If the arbitrator verifies that the labor organization has been designated or selected as the bargaining representative by a majority of the employees in an appropriate unit, the tribe shall, upon request, recognize the labor organization as the exclusive bargaining agent and bargain in good faith with the labor organization in an effort to reach a collective bargaining agreement. However, the arbitrator shall disallow any claim by a labor organization [which] that is dominated or controlled by the tribe.

(4) (A) Any individual or organization claiming to be injured by a violation of any provision of this subsection shall have the right to seek binding arbitration under the rules of the American Arbitration Association. Such individual or organization shall file a demand for arbitration with the tribe not later than one hundred eighty days after the employee or labor organization knows or should know of the tribe's violation of any provision of this subsection. The demand shall state, in plain language, the facts giving rise to the demand.

(B) The demand for arbitration shall also be served upon the Connecticut office of the American Arbitration Association. Absent settlement, a hearing shall be held in accordance with the rules and procedures of the American Arbitration Association. The costs and fees of the arbitrator shall be shared equally by the tribe and the labor organization.

(C) The decision of the arbitrator shall be final and binding on both

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parties and shall be subject to judicial review and enforcement against all parties in the manner prescribed by chapter 909.

(5) A tribe shall not retaliate against any individual who exercises any right under the Employment Rights Code. Any individual or organization claiming to be injured by a violation of the provisions of this section shall have the right to seek binding arbitration pursuant to subdivision (4) of this subsection.

Sec. 32. Section 32-204 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2013*):

The general purpose of the authority shall be to stimulate new spending in Connecticut and to encourage the diversification of the state economy through the construction, operation, maintenance and marketing of a conference or exhibition facility that will create new jobs, add to the benefits of the hospitality industry, broaden the base of the tourism effort and stimulate substantial surrounding economic development and corresponding increased tax revenues to the state. The primary purpose of the authority shall be to attract and service large conventions, tradeshow, exhibitions and conferences, preferably those whose attendees are predominantly from out-of-state; the secondary purpose of the authority, at times when its primary purpose cannot be fulfilled, shall be to attract and service local consumer shows, exhibitions and events [which] that generate less new spending in Connecticut. For these purposes, the authority shall have the following powers: (1) To have perpetual succession as a body corporate and to adopt procedures for the regulation of its affairs and the conduct of its business as provided in subsection (f) of section 32-203; to adopt a corporate seal and alter the same at its pleasure; and to maintain an office at such place or places within the state as it may designate; (2) to sue and be sued; to contract and be contracted with, provided, if management, operating, or promotional contracts or agreements or other contracts or agreements are entered into with

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nongovernmental parties with respect to property financed with the proceeds of obligations the interest on which is excluded from gross income for federal income taxation, the board of directors will ensure that such contracts or agreements are in compliance with the covenants of the authority upon which such tax exclusion is conditioned; (3) to acquire, by gift, purchase, condemnation or transfer, lands or rights-in-land in connection therewith and to sell, lease as lessee or as lessor, provided such activity is consistent with all applicable federal tax covenants of the authority, transfer or dispose of any property or interest therein acquired by it, at any time; and to receive and accept aid or contributions, from any source, of money, labor, property or other things of value, to be held, used and applied to carry out the purposes of sections 32-200 to 32-212, inclusive, as amended by this act, subject to the conditions upon which such grants and contributions are made, including, but not limited to, gifts or grants from any department, agency or instrumentality of the United States or this state for any purpose consistent with said sections; (4) to formulate plans for, acquire, finance and develop, lease, purchase, construct, reconstruct, repair, improve, expand, extend, operate, maintain and market the project, provided such activities are consistent with all applicable federal tax covenants of the authority; (5) to fix and revise from time to time and to charge and collect fees, rents and other charges for the use, occupancy or operation of the project, and to establish and revise from time to time, regulations in respect of the use, operation and occupancy of any such project, provided such regulations are consistent with all applicable federal tax covenants of the authority; (6) to employ such assistants, agents and other employees as may be necessary or desirable to carry out its purposes and to fix their compensation; to establish and modify personnel procedures as may be necessary from time to time and to negotiate and enter into collective bargaining agreements with labor unions; (7) to engage architects, engineers, attorneys, accountants, consultants and such other independent professionals as may be necessary or desirable

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to carry out its purposes; to contract for construction, development, concessions and the procurement of goods and services and to establish and modify procurement procedures from time to time to implement the foregoing in accordance with the provisions of subsection (b) of this section; (8) to adopt procedures with respect to contractors and subcontractors engaged in the construction of the project [which] that require such contractors or subcontractors (A) to take affirmative action to provide equal opportunity for employment without discrimination as to race, creed, color, national origin, ancestry, sex, gender identity or expression, marital status, age, lawful source of income, [mental retardation] intellectual disability, mental disability or physical disability, including, but not limited to, blindness or deafness, and (B) to ensure that the wages paid on an hourly basis to any mechanic, laborer or workman employed by such contractor or subcontractor with respect to the project shall be at a rate equal to the rate customary or prevailing for the same work in the same trade or occupation in the town and city of Stamford; (9) to engage in and contract for marketing and promotional activities to attract national, regional and local conventions, trade shows, exhibitions, banquets and other events in order to maximize the use of the project and to carry out the purposes of sections 32-200 to 32-212, inclusive, as amended by this act; (10) to acquire, lease, hold and dispose of personal property for the purposes set forth in sections 32-200 to 32-212, inclusive, as amended by this act; (11) to procure insurance against any liability or loss in connection with its property and other assets, in such amounts and from such insurers as it deems desirable and to procure insurance for employees; (12) to borrow money and to issue bonds, notes and other obligations of the authority to the extent permitted under sections 32-200 to 32-212, inclusive, as amended by this act, to fund and refund the same and to provide for the rights of the holders thereof and to secure the same by pledge of assets, revenues, notes and state contract assistance as provided in said sections and such state taxes as the authority shall be entitled to receive pursuant to the

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provisions of said sections; (13) to invest any funds not needed for immediate use or disbursement in obligations issued or guaranteed by the United States of America or the state of Connecticut and in other obligations [which] that are legal investments for savings banks in this state and in time deposits or certificates of deposit or other similar banking arrangements secured in such manner as the authority determines; (14) to do anything necessary and desirable, including executing reimbursement agreements or similar agreements in connection with credit facilities, including, but not limited to, letters of credit or policies of bond insurance, remarketing agreements and agreements for the purpose of moderating interest rate fluctuations, to render any bonds to be issued pursuant to sections 32-200 to 32-212, inclusive, as amended by this act, more marketable; (15) to do all acts and things necessary or convenient to carry out the purposes of sections 32-200 to 32-212, inclusive, as amended by this act, and the powers expressly granted by said sections.

Sec. 33. Subsection (a) of section 38a-488a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2013*):

(a) Each individual health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 delivered, issued for delivery, renewed, amended or continued in this state shall provide benefits for the diagnosis and treatment of mental or nervous conditions. For the purposes of this section, "mental or nervous conditions" means mental disorders, as defined in the most recent edition of the American Psychiatric Association's "Diagnostic and Statistical Manual of Mental Disorders". "Mental or nervous conditions" does not include (1) [mental retardation] intellectual disability, (2) learning disorders, (3) motor skills disorders, (4) communication disorders, (5) caffeine-related disorders, (6) relational problems, and (7) additional conditions that may be a focus of clinical

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attention, that are not otherwise defined as mental disorders in the most recent edition of the American Psychiatric Association's "Diagnostic and Statistical Manual of Mental Disorders".

Sec. 34. Subsection (a) of section 38a-514 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2013*):

(a) Except as provided in subsection (j) of this section, each group health insurance policy, providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469, delivered, issued for delivery, renewed, amended or continued in this state shall provide benefits for the diagnosis and treatment of mental or nervous conditions. For the purposes of this section, "mental or nervous conditions" means mental disorders, as defined in the most recent edition of the American Psychiatric Association's "Diagnostic and Statistical Manual of Mental Disorders". "Mental or nervous conditions" does not include (1) [mental retardation] intellectual disability, (2) learning disorders, (3) motor skills disorders, (4) communication disorders, (5) caffeine-related disorders, (6) relational problems, and (7) additional conditions that may be a focus of clinical attention, that are not otherwise defined as mental disorders in the most recent edition of the American Psychiatric Association's "Diagnostic and Statistical Manual of Mental Disorders".

Sec. 35. Subdivision (12) of section 38a-816 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2013*):

(12) Refusing to insure, refusing to continue to insure or limiting the amount, extent or kind of coverage available to an individual or charging an individual a different rate for the same coverage because of physical disability, mental or nervous condition as set forth in section 38a-488a, as amended by this act, or [mental retardation]

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intellectual disability, except where the refusal, limitation or rate differential is based on sound actuarial principles or is related to actual or reasonably anticipated experience.

Approved June 18, 2013